DOMESTIC ABUSE STATUTORY NEEDS ASSESSMENT

June 2021

Introduction and Acknowledgements

Thank you to all the survivors and services who have provided the vital data and insights for this report. We would like to especially thank those that took time out of their busy schedules to help arrange interviews, focus groups and run additional reports to support our understanding and analysis. This report would not have been possible without the leadership and strong strategic buy-in of all partners in Tameside and we hope we have provided you with a useful document to augment and strengthen your existing practice.

As you build an action plan that accompanies this statutory needs assessment and your resulting strategy we would ask you to remember that survivors tell us that the most important things to them are:

- Believing someone when they say they have experienced violence and abuse (92.6% strongly agreed, 7.4% agreed).
- Having a good understanding violence and abuse (92.3% agreed or strongly agreed. One person disagreed, and one neither agreed nor disagreed).
- Providing information about other help and support available (81.48% strongly agreed, 18.52% agreed).
- Being clear about confidentiality and information sharing (81.48% strongly agreed, 18.52% agreed).

The AVA team were impressed with the dedication and skill of the majority of professionals they spoke to during this piece of work. Professionals were proud of the services they worked in and confident that they were meeting the needs of victim-survivors. Although all agreed that more could be done they were supportive of the process and open to discussion with the AVA team about the needs assessment and identifying areas of improvement. Many expressed confidence in the better outcomes as a result of this needs assessment work;

> ***"****The discussion with you has really made me think about how we capture the work that takes place, so that our data illustrates the work we are involved in. So, thank you, it will help inform the review of our system."*
>
> ***Feedback from a professional following interview***

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Executive Summary

1. Data

1.1 Tameside has a high level of reported domestic abuse. The reported rate is higher than both Tameside's closest statistical neighbours and eight points higher than the England average.

1.2 The data repeatedly finds that the police form the largest source of the referral route for residents.

1.3 Evidence suggests a large number of incidents of domestic abuse go unrecognised where survivors might be accessing mental health support, accident and emergency and adult social care.

1.4 There is a significant and pervasive data gap around the identity and protected characteristics of both victim-survivors (adult and child) and perpetrators – in particular we call attention to the lack of analysis by sex and gender identity and by race, faith and ethnicity.

1.5 The needs of children and young people are not adequately recorded or understood at a strategic or operational level.

1.6 There are significant opportunities to bring agencies together through a stronger approach to suicide prevention in Tameside. This should include an analysis of the needs of victim-survivors of domestic abuse and identification of perpetrator suicide.

1.7 Mental health services, adult social care, and health care services are identified as sources for data improvement going forward.

1.8 Professionals repeatedly acknowledged the financial harms of domestic abuse, forced debt, and high economic need. Data on these needs is not consistently reported on or collected.

1.9 Each service sees only a small picture of a victim-survivors life, despite the widely acknowledged Multiple Disadvantage and high level of need in Tameside. No one service holds a full picture of the needs of a family – children's focused services do not consider the needs of adults with enough depth, services responding to the needs of adults do not collect data on the numbers of children indirectly supported through their work and the numbers

needing direct support. There is work to do as Tameside progresses on it's journey towards a CCR to join data up to provide smooth journeys through services.

2. Survivors Views

2.1 Survivors felt that there was a shortage of housing and appropriate housing advice.

2.2. Survivors identified high levels of mental health need, and yet difficulties accessing mental health support. In particular, survivors highlighted the lack of specialised mental health support for PTSD.

2.3 Survivors reported high rates of emotional abuse and coercive control. In response to questioning around needs for improvement, survivors highlighted a better understanding around emotional abuse from professionals and society writ large.

2.4 Survivors highlighted the impact of financial and economic abuse, specifically the stress caused and additional hardship where debt is incurred during abuse. Survivors highlighted the need for emergency funding and support with painting, decorating and white goods when moving into new accommodation.

2.5 Survivors reported higher than average rates of turning to the police and/or criminal justice professionals for support around abuse. This is suggestive of a high level of survivors reaching a crisis point, and a potential lack of early intervention.

2.6 Survivors reported the need for better follow up and aftercare to deal with post-separation abuse.

3. Professionals

3.1 Professionals in Tameside are strong multi-agency workers – they enjoy joined up training offers, and are proud of the services they supply in partnership.

3.2 There were particular gaps identified around identification of domestic abuse victim-survivors and perpetrators in adult social care, mental health offer, housing, and health services.

3.3 There is a lack of consistency in responding to and managing perpetrators.

3.4 Professionals talked about the need for flexibility in the service offer, understanding how housing, mental health, substance misuse and domestic abuse interact and encouraging greater perseverance in engagement and support for residents facing high levels of need

3.5 Professionals identified services with large statutory responsibilities that had high levels of problematic attitudes to victim-survivors.

Methodology

The AVA team have worked hard to ascertain an accurate picture of the needs of Tameside residents and understand how Tameside's population compares with its closest statistical neighbours to help contextualise the numbers being identified and the areas performance. We agreed with the needs assessment working group that the key statistical neighbours for Tameside were Rotherham, Doncaster and St Helens.

In addition to nationally published data sources we were provided with a number of key local data sources including MARAC data, the Domestic Abuse Scorecard, Reporting Data from Bridges and data from The Women and Families Centre. In addition, we made requests for data from the Enhanced Maternity Team, Tameside Housing, Adult Social Care and Children's Social Care. This needs assessment leans on this local data and its comparators with national published data sets.

A note on data analysis; we are dependent on the data provided to us by service providers in Tameside and publicly available national data sets some of which are described above. It is important to consider the following with regards to the data presented across this needs assessment:

- We know that domestic abuse is characterised by patterns of coercive control and incidents rather than single incidents of crime types and so the counting of incidents reported to the police or attendance at A&E does not equate to a number of victims.
- We also know from our work on Multiple Disadvantage that many survivors need to make use of many services, and that the same survivor may well use a range of voluntary and universal services. Although cases can be heard and information shared through the MARAC, when we look at data from individual services it can be difficult to identify the same survivor traveling through services being counted in different data sets that are monitored and collected in different ways.
- We are working in the context where domestic abuse is still a largely hidden crime, it is significantly underreported and difficult for victim-survivors to disclose. Gendered stereotypes and structural discrimination can exacerbate under-reporting.

In order to ensure that this needs assessment went beyond published figures we also carried out a range of interviews with staff and survivors.

We carried out semi-structured interviews with key professionals in service areas of interest. We spoke with a manager or safeguarding lead and carried out focus groups with frontline professionals. We carried out focus groups with all housing teams and early help. We carried

out one to one interviews with specialist victim-survivor workers across community and refuge services and located across risk levels. We talked to representatives from Mental Health, Housing, Adult Social Care, Children's Social Care, Early Help, Drug and Alcohol Services, Maternity services and the Youth Offending Team.

In order to hear the voices of residents and the opinions and experiences of survivors in the borough, we devised a survivor survey, which was signed off by the needs assessment working group and distributed via Survey Monkey. We worked hard on engagement and reach and it was distributed through operational professionals, local social media channels, health watch newsletters, patient representative groups, the youth council, the care leavers council and through word of mouth. The timing of the survey – coinciding with local elections, housing restructure, Eid and an Ofsted inspection potentially limited its reach but none the less it has given us data and insight that sit alongside the numerical data collected in DA scorecards and local data sets[1]. Ultimately, we received 52 responses to our survivor survey.

Victim-survivor demographics from the survey

Age: While the survivor survey wasn't able to reach survivors over the age of 65, 16% of our sample was over 55 and we interviewed two survivors over the age of 50. The majority of survivors represented in this analysis were between the ages of 25 – 44, with just 6.7% under the age of 18 and 4.4% between 18 and 24 yrs old.

Gender: The majority of survivors captured in the survey are female, at 84% of the sample. The remaining 13.6% were male and 2.3% non-binary. This means that male survivors are over represented in the data presented below.

Sexuality: The majority of the survivors that we surveyed were heterosexual (86.7%), 11% of the survivors identified as bi-sexual and the remaining 2.3% identified as gay or lesbian.

Marital status: Roughly half (51%) of the survivors surveyed were married/civil partnered or cohabiting and 37.2% were single.

Disability: Given the low numbers of disabled people in the data collected locally we are pleased that 28% of participants of the survey reported having a disability. This is possibly a result of the intensive outreach with patient representative groups and community members of Healthwatch and the needs of survivors of domestic abuse (the national average is 18%). Of the disabilities discussed, the majority had high rates of mental ill-health, just over 70% of these disabled survivors identified their mental health as their disability. 29.4% identified as physically disabled, again higher than in the local documented demographic need.

[1] Appendix 2 has a full list of the data collected through the survey

Race/Ethnicity: The vast majority of victim-survivor respondents white (86.4%), although this does represent higher levels of engagement with Black and Minoritised survivors in comparison to other cohort analysis in Tameside (e.g. MARAC). We are grateful to Diversity Matters North West for using their networks to engage survivors as the largest category of other was Asian and Asian British. We also heard from victim-survivors who listed themselves as Black British and Mixed Ethnicity. We recognise that we have a gap in the identification of Polish survivors and suggest that further work could be done to ensure their needs are understood and planned for locally.

Children: The majority of survivors surveyed had children - with there being an even split among those who had 1,2 or 3 children. Just 37.8% of the sample had no children.

To ensure that we were able to offer a representative view on survivors' experiences we approached Bridges to see if we could target particular groups of survivors, this meant that we were able to talk to two male survivors, two aged over 50, and two who had particular needs around health and housing.

We asked survivors to identify what types of domestic abuse they had experienced in the form of tick boxes in the Survey Monkey:

- The majority (89.7%) had experienced emotional abuse
- Jealous and controlling behaviours were experienced by 72.4% of respondents
- Physical abuse was experienced by 72.4% of respondents
- Financial control and sexual abuse were experienced by 37.9% of the sample.

Less frequently experienced were surveillance and stalking and harassment or unwanted attention in public spaces (24.1% both). One respondent mentioned forced marriage, and one ‘honour’ based violence. When survivors were asked about the nature of the abuse, the majority identified that the abuse was perpetrated by a partner (72.4%) with family members being the next largest category (31.3%).

Chapter One:
The National Context Arising from The Domestic Abuse Act

Orientation

1.1 Definitions

The new Domestic Abuse Act (2021) brings in, for the first time, a cross-government statutory definition of domestic abuse. The definition of domestic abuse is in two parts. The first part of the definition deals with the relationship between the abuser and the abused, the second defines what constitutes abusive behaviour.

'Abusive behaviour' is defined in the Act as any of the following: *"*physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional or other abuse.*"*

For the definition to apply, both parties must be aged 16 or over and 'personally connected'. People who are 'personally connected' are defined as: intimate partners, ex-partners, family members or individuals who share parental responsibility for a child. The existing legislation on coercive control has been extended to include separation post abuse meaning victims are protected and given rights where ex-partners or family members (e.g. children) no longer live in the same house.

Part 1 of the Act also provides that a child who sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse.

1.2 Changes Arising from The New Act and Statutory Duty

Key changes arising from the new Act are summarised in the text box below.

- The Act creates a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence. As part of this definition, children will be explicitly recognised as victims. Controlling or Coercive behaviour (CCB) offences have also been extended to cover post-separation abuse
- The Act creates a new offence of non-fatal strangulation
- The Act extends the 'revenge porn' offence to cover the threat to disclose intimate images
- The Act clarifies the law to further deter claims of "rough sex gone wrong"
- The Act creates a statutory presumption that victims of domestic abuse are eligible for special measures in the criminal, civil and family courts
- The Act establishes the office of the Domestic Abuse Commissioner
- The Act places a duty on local authorities in England to: provide support to victim/survivors and their children in refuges and other safe accommodation; to ensure victims of domestic abuse do not lose a secure lifetime or assured tenancy; and that all eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance
- The Act places "Clare's Law" on a statutory footing
- The Act enables survivors to make a barring order to prevent being repeatedly brought back to court by the perpetrator
- The Act prohibits GPs and other health professionals from charging a victim/survivor for a letter to support an application for legal aid
- The Act enables domestic abuse offenders to be subject to polygraph testing as a condition of their licence following their release from custody
- The Act extends the extraterritorial jurisdiction of the criminal courts in England and Wales, Scotland and Northern Ireland to further violent and sexual offences
- The Act provides for a new Domestic Abuse Protection Notice and Domestic Abuse Protection Order, which will prevent perpetrators from contacting their victims, as well as force them to take positive steps to change their behaviour, e.g. seeking mental health support
- The Act introduces a statutory duty on the Secretary of State to publish a domestic abuse perpetrator strategy (to be published as part of a holistic domestic abuse strategy).

See Appendix 2 for a full explanation of the new statutory duty.

1.3 The Coordinated Community Response

The Tameside response to domestic abuse is rooted in an understanding of asset-based neighbourhood approaches and the 'coordinated community response (CCR)'. The CCR is a collaborative multi-agency approach to supporting victim-survivors pioneered by the charity Standing Together.[2]

Domestic abuse is a complex social problem, and as such, survivors and their children often find themselves attempting to navigate or seek support from a number of different agencies, often with competing demands or conflicting information collection requirements.

The CCR approaches victim-survivors from a 'zoomed out' perspective, emphasising the need for a broad holistic response through joined up agency working. In our time with Tameside we have witnessed first hand the respectful nature of professionals' working arrangements, the passion for joined up working, enabling resources to be spent wisely and sharing training and development across agencies. Professionals talked about wanting to avoid duplication of service offers and ensure the well-being of clients by guaranteeing that they were not overwhelmed by a multitude of professionals.

Practice Recommendation:

- The strong partnerships and approach to multi-agency working that will enable the CCR to flourish should be matched through a consistent approach to data collection, outcomes frameworks and monitoring of impact across agencies.

The CCR requires consistent communications across residents, professionals and victim-survivors to prioritise early intervention. We asked survivors where they felt communications campaigns would be most useful. Survivors responding to AVA identified that the biggest difference for them in terms of their help seeking would be a greater understanding around emotional abuse.

The CCR places an emphasis on the networks of friends and families and how these can be useful sources of information and support. This was echoed in the way survivors described early help seeking. Survivors told us that they asked friends and family for help first and how important those early conversations were in helping them to identify the perpetrators' behaviour as abusive.

[2] For more on their work on the CCR, see: https://www.standingtogether.org.uk/what-is-ccr

Half of survivors told us that it was a friend or family member who first raised concerns about the perpetrators behaviour, this led them to do their own research (20% access information through a search engine).

Many survivors highlighted the time that it took to come to the understanding and what that meant for their identity.

Survivors also talked about always knowing on some level that that the behaviour was abusive but had internalised ideas about domestic abuse being physical and that if information had been available about coercive or controlling behaviours they might have had an earlier identification of the abuse:

"I didn't think anyone would believe the abuse I was getting from my ex -husband. Mainly because he made me believe that everything was my fault. I always believed DV was where you got hit, but it's much more than that, and maybe I would have asked for help years ago had that information been made available."

Survivor interview

Survivors identified the key areas for future campaigns are presented below in order of importance:

- Understanding emotional abuse/coercive control: 100% (27), important, of which 96.3% (26) very important
- Understanding the impact of domestic abuse on children: 100% (27) important, of which 88.9% (24) very
- Awareness raising that anyone can be a victim of domestic abuse (e.g. regardless of age, gender, sexuality, ethnicity, religion): 100% (27) important, of which 85.2% (23) very
- Understanding the mental health impact of abuse: 96.3% (26) important, of which 85.2% (23) very
- Awareness raising for friends/family around recognising when someone is being abused and how to support them: 96.3% (26) important, of which 85.2% (23) very
- Understanding financial/economic abuse: 96.3% (n 26) important, of which 74.1% (20) very
- Awareness raising for perpetrators around recognising their own behaviours: 92.6% (25) important, of which 88.9% (24) very.

Practice Recommendations:

- Tameside's strategic domestic abuse partnership should consider its awareness raising activities to align with local survivor priorities.

- Tameside should target communications at the friends and families of survivors, resourcing them with information and key messages such as the Women's Aid Ask Me scheme or the Safe Lives 'Reach In' campaign.

Chapter Two:
Understanding The Local Population and Service Offers

Orientation

2.1 The Local Population

The Borough of Tameside is a Unitary Authority in the North West of England. It is positioned on the East of Greater Manchester and part of the Greater Manchester Combined Authority. It sits on the edge of the Peak District and is a recovering industrial heartland. As one of the most reasonable places to buy in the North West it has a growing population, more people now live in Tameside than at any other time. Health analysts suggest that this will continue to increase across the next 10 years, in 2014 the census put the population at 220,800 while in 2021 the local authority estimates its population at 226,493.

2.1.1 Health Indicators

It is generally accepted that the health of Tameside residents is worse than the English average.[3] There is a high rate of alcohol related harm, high numbers of self harm and self injury and approximately two thirds of adults in Tameside are overweight or obese.

Markers of mental ill-health and the chronic impact of domestic abuse and VAWG related crime types are stark in Tameside - it has the second highest level of self-harm in Greater Manchester (increasing year on year for the last 5 years).

Alongside a growing population and the indicators for low population health and well-being the residents of Tameside are also aging. The highest percentage of population growth is in the age group 65+ at the last JSNA. In 2016, there were an estimated 308 people of a pensionable age for every 1,000 people of a working age. By 2037, this is projected to increase to 365 people. This increase will have an impact on the work of universal services but also on the demand for healthcare and housing.

[3] https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E08000008.html?area-name=Tameside

Given this population trend we wanted to ensure that we explicitly considered the needs of older victim-survivors in this assessment.

Traditionally older people's experience of domestic abuse has been hidden. The national charity Age UK has successfully campaigned to ensure that ONS data on the numbers of domestic abuse survivors is increased to count experiences up to the age of 74 but this still leaves a large number of survivors uncounted.

In the Women's Aid Annual Audit, it was noted that the oldest survivor using community based services was 91 years old Women's Aid qualified this with "Older women were underrepresented in the sample. Only 3.8% of service users in the total sample were 61 or over and this fell to 1.9% in refuge services. This is unlikely to reflect need, as we know that older women experience particular barriers in accessing support.

The most recent Femicide Census Report showed that between 2009 and 2018, 14% of femicide victims were aged 66 and over. Of these, 34% were killed by intimate partners, and 25% by their sons (Femicide Census, 2020)".

2.1.2 Economic Indicators

Tameside is one of the 20% most deprived districts in England and 18.9% (8,580) children live in low income families.[4] Although there is diversity within the economic make up of Tameside 13.4% of Tameside residents live in income-deprived households. In March 2019, 3.9% of working age residents in Tameside claimed benefits.

Almost a quarter of children under the age of 16 are living in low income families across Tameside and Glossop (23.7%), this equates to around 10,473 children compared to 20.1% in England.[5]

While socio-economic status doesn't increase the likelihood of you experiencing domestic abuse, it can limit access to the services you need to recover and limit the options for escape and freedom. Furthermore as the Domestic Abuse Bill brings into force a new understanding of the links between economic freedom and coercive control, understanding the socio-economic make up of Tameside is important in planning service interventions and the needs of victim survivors.

[4] https://fingertips.phe.org.uk/profile/health-profiles/data#page/13/ati/202/are/E08000008
[5] Income and poverty: (2014 census data and 2017/18 health needs assessment data, and Local authority health profile 2018)

2.1.3 Population Identity – Military Families

Tameside has a significant number of military families in its resident population. The Ministry of Defence estimates that 4.2% of people living in Greater Manchester have served in the Armed Forces. Using this and other MoD data sources, we estimate that in 2016 there were approximately 7,500 people living in Tameside who have served in the UK's Armed Forces. The wider ex-service community includes adult and child dependents of ex-military personnel. The Royal British Legion estimates that in England in 2012, 1.5% of the population were children of ex-service personnel, and 3.2% of the population were adult dependents of ex-service personnel.

Research would suggest that domestic abuse is an issue of concern in military families and may be higher in prevalence than in civilian populations, In 2009, the National Association of Probation Officers reported that of all cases under probation in England and Wales involving a member of the UK Armed Forces, the most common conviction was for violence in a domestic setting.

2.1.4 Population Identity - Sex and Gender

The JSNA provides an analysis of sex across the 30 wards covered by the JSNA. 26 out of 30 have higher numbers of female residents compared to males. This is more apparent in the population aged 65 years and over where 28 wards out of 30 have more female residents than males.

This is important when considering the needs of domestic abuse survivors because domestic abuse is gendered issue. We see this most clearly when thinking about the needs of women, men and LGBT+ survivors and draw on the articulation by Meghan Field and James Rowlands in the Commissioning for Inclusion Guidance published in 2020;

"LGBT+ inclusive responses should not be regarded as incompatible with programs tackling gender-based violence and violence against women and girls, or indeed those working with men and boys. LGBT+ people's experiences of domestic abuse are often rooted in patriarchy, gender inequality and deep rooted social norms, attitudes and behaviours that discriminate and oppress women and girls across all communities and also impact on men and boys. Developing a greater understanding of the needs of LGBT+ survivors can invigorate and meaningfully inform the endeavour of striving to end all identity-based violence. As part of this work it is, however, important to understand what is the same and what may be different for LGBT+ survivors, including the dynamics and nature of abuse".

2.1.5 Population Identity - Race and Ethnicity

2014 Census data builds a picture of the ethnic and racial makeup of Tameside[6] - there is growing diversity in the borough and strong leadership on community engagement demonstrated by the targeted campaign around the census regarding Polish residents. Census figures tell us that:

- 91.4% of people living in Tameside were born in England. Other top answers for country of birth were 0.9% Pakistan, 0.9% Scotland, 0.8% Bangladesh, 0.7% India, 0.6% Ireland, 0.4% Wales, 0.3% Northern Ireland, 0.2% Kenya, 0.2% China.
- 15.8% of the local population are from an 'ethnic minority' group.
- The religious make up of Tameside is 64.0% Christian, 23.2% No religion, 4.4% Muslim, 1.5% Hindu, 0.2% Buddhist.
- 95.3% of people living in Tameside speak English. The other top languages spoken are 1.0% Bengali, 0.8% Polish, 0.6% Urdu, 0.5% Gujarati, 0.3% Panjabi, 0.1% All other Chinese, 0.1% Italian, 0.1% Cantonese Chinese, 0.1% French.

A number of professionals across a range of services talked about the variety of needs with regard to race and ethnicity and particular barriers for victim-survivors who had Bangladeshi heritage. Professionals identified that with their residents they faced particular:

- Language barriers
- Limited access to community centres
- High numbers of unregistered people resident in Tameside making it hard to reach and tailor a service offer for these residents.

While there has been no data analysis possible to test these assumptions, more disaggregated data providing an evidence base on this cohort, alongside better training and recording on race, faith and ethnicity, may act as factors to improve support for residents from Black and Minoritised communities.

Practice Recommendations:

- All frontline staff should receive training on understanding the language on race, ethnicity and identity to enable better data collection on race and ethnicity in all services.

[6] https://www.tameside.gov.uk/demographic-information

Tameside has a strong voluntary sector and universal service offer designed to welcome and settle asylum seekers and refugee members of the community. Official figures on the numbers of asylum seekers and refugees are hard to quantify but in June 2019, the North West had a rate of 13.51 asylum seekers per 10,000 people in the region, the second-highest regional density in the UK.[7]

In the latest JSNA the Tameside figure for 2017 is 1,679 people registered as asylum seekers in Tameside, and notes that this is a rise on the previous year.

Data Recommendations:

- Increased consistency in data collection on Race and Ethnicity would enable better understanding of under-representation/over representation of ethnic groups of adult and child survivors.
- Tameside should check engagement from sections of the community with protected characteristics against published census figures as part of strategic performance assessments of services.

We know that refugees and asylum seekers have large amounts of trauma and experiences of violence as part of their persecution and that systems designed to provide protection can increase vulnerability to exploitation and abuse. Although they will make up a small number of the domestic abuse survivors in Tameside they are worth considering due to high needs and the particular needs that they have for recovery.

Women in the asylum system have been able to access domestic abuse refuges since 2019 but there are none listed in the Bridges referral data for refuge services. We do have a case study from the Women and Families Centre for a refugee woman who self referred for support around domestic abuse, housing and immigration rights advice.

Refuges are not a source of support for women who become Appeal Rights Exhausted after coming through the UK asylum system. This cohort of women faces risks of homelessness, destitution and sexual exploitation due to lack of access to public funds.[8] We were not able to quantify the numbers of residents with these needs in Tameside however it is our opinion that it is due consideration by Tameside given the national dataset on the needs of migrant

[7]https://northwestrsmp.org.uk/statistics/#:~:text=In%20June%202019%2C%20the%20North,regional%20density%20in%20the%20UK

[8]https://www.refugeecouncil.org.uk/latest/news/the-governments-new-strategy-on-violence-against-women-and-girls-can-no-long-ignore-women-in-the-asylum-system/

women and the lack of provision for these survivors in the new Act. Southall Black Sisters found that Women with NRPF are vulnerable to high rates of domestic and sexual violence, sexual and economic exploitation, domestic homicide (including so called 'honour' killings) and suicide[9].

2.1.6 Population Identity – Sexuality

Data collected through the annual population survey and the GP patient survey suggests that Tameside is in line with the ONS estimated 2% of the population who are LGB[10] in Tameside this would equate to approximately 3,588 people.

The national LGBT+ charity Galop has led the way in strengthening the national understanding of the needs of LGBT+ survivors of domestic abuse. Their summary set out in their commissioning guidance indicates that more than one in four gay men and lesbian women and more than one in three bisexual people report at least one form of domestic abuse since the age of 16. Lesbian women report similar rates of domestic abuse to that of heterosexual women. Bisexual women are twice as likely to disclose intimate partner violence compared to heterosexual women. Gay and bisexual men might be twice as likely to experience domestic abuse compared to heterosexual men. Prevalence rates of domestic abuse may be higher for transgender people than any other section of the population. In Tameside the LGBT+ population is hard to quantify. It is likely that Tameside's LGBT+ population will be higher than its statistical neighbours due to its proximity to Manchester which has a strong reputation as a gay friendly city.

2.2. Children in Tameside

The needs of children and young people in Tameside appears to be a clear strategic and operational priority for the borough, with an embedded focus on participation and co-production. In 2019 Ofsted noted that a change in senior leadership had supported the adoption of a much strengthened 'whole council' commitment to improving the quality and impact of children's services.[11]

[9] https://southallblacksisters.org.uk/wp-content/uploads/2021/01/DA-Bill-Briefing-Paper-2.pdf
[10] In 2016, the ONS estimated that 2% of the UK population, or just over 1 million people, identify as having a minority sexual orientation.
[11] https://files.api.ofsted.gov.uk/v1/file/50088888

The Tameside Emotional Health and Well-being Transformational Plan sets out a clear vision for children and young people despite challenges faced by austerity budgets, and voluntary sector changes. Tameside is aiming for:

"An emotional wellbeing and mental health system that is truly personalised, joined up, supports children and young people to stay well and provides the very best support and care, when and where they need it. For children and families, this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs and of those who care for them".[12]

Multiple studies describe how children who are exposed to domestic violence experience greater levels of trauma, anxiety, and depression, as well as increased behavioural and cognitive problems.[13] Although a strengths based approach to child development encourages us to believe that with the right service offer and network of support children and young people recover from their abuse experiences and go on to live happy, healthy lives.

We have found it harder to paint a picture of the needs of children and young people in Tameside from published data sources and yet they make up just under a quarter of the residents of the borough (children and young people under the age of 20 years represent 24.4% of the population of Tameside).

2.2.1 Health Indicators

The poorer health outcomes of the adult population are mirrored in children and young people's life experiences and yet looking at local data in comparison to England wide averages a complex picture emerges.

The Kings Fund sets out several key indicators of child health and well-being noting that these are influenced by wider socio-economic determinants. For the Kings Fund a key indicator of the health and well-being of Children is their dental health. In Tameside the dental health of children is worse than the English average. In Tameside 34.1% of 5 year olds have one or more decayed, filled or missing teeth against an English average of just 23.3%.[14]

[12] transformation_plan_NHSE_Final_v10.2.pdf (tamesidesafeguardingchildren.org.uk)
[13] https://safeandtogetherinstitute.com/wp-content/uploads/2020/05/DVIResearchBriefing_Parenting-Strengths_2017_HiRes.pdf
[14] Tooth decay in 5-year-olds continues to decline - GOV.UK (www.gov.uk)

Interestingly a key determiner of health and well-being is obesity rates, there are not elevated levels of childhood obesity in Tameside. At the point of reception these figures are in line with the English national average (9.8% of children in Reception). Tameside rates at the end of year six are 21.2% this is not a statistically significant increase from the English national average (21.0%).

Public Health data on the health and well-being indicators for Tameside noted the high teenage pregnancy rate. In Tameside the number of under 18s giving birth is 28 per 1,000 vs an English average of 16.7 per 1,0000.[15] This amounts to 98 girls becoming pregnant in an average year, no demographic detail is available on the backgrounds of these young women.

It is estimated that 3,124 children aged 5 to 16 years have a diagnosed mental health condition in Tameside. Of these 38% are related to emotional conditions such as anxiety and depression. Around 61% have conduct disorders such as behavioural issues. 17% have hyperkinetic conditions relating to developmental issues. It is also estimated that 3,349 16 to 24 year olds have Attention Deficit Hyperactivity Disorder (ADHD) and 3,183 children and young people have an eating disorder. Around 758 (2%) school aged children are supported in school due to social, emotional and mental health needs.

2.2.2 Population Indicators

22.2% of school aged children are from a minority ethnic group but there is little analysis of the population identity of children and how this compares to adult race and ethnicity patterns of the borough.

Support for unaccompanied asylum-seeking children is deemed to be effective by Ofsted. When children and young people arrive in the UK, the local authority provides suitable accommodation, and support is progressed well. Practice with these children and young people shows good cultural competence, not only in finding suitable placements, but also in their wider support.

Given that the new Domestic Abuse Act recognises children as victims of domestic abuse in their own right AVA make a clear recommendation for increased data collection, survivor consultation and a child focused outcome framework to ensure that the borough meets the needs of quarter of its residents.

[15] Tameside.pdf (psnc.org.uk)

2.3 A Local Approach to Domestic Abuse – Access and Services

Local services matter to victim-survivors in Tameside and not just for housing options but all services. Understanding how this informs service design and delivery and how we need to reach into communities has been important learning for the AVA team. We asked victim-survivors through our survey and through interviews how easy it was for them to find the information they needed about domestic abuse within the community and what motivated their early help seeking. About half of all survivors told us that they sought information first from a friend or family member:

> *"It was one of my friends [who helped me identify domestic abuse]. I'd thought things with my partner weren't right, and I spoke to a friend at work and she said I should speak to women's aid. There was loads of denial at first, I didn't think I could be that daft to be in that situation, I don't think of myself as a stupid person. I had a google – the big national ones came up, and then Bridges."*
>
> ***Survivor interview***

The next largest source of information supporting the identification of abuse was the police or a criminal justice intervention (44.8%), while health and education were 34.5%. Articles or news on social media reached just 17% of local survivors and interestingly no survivors had identified their experiences as abusive through either national or local targeted awareness raising campaigns.

2.3.1 Understanding Barriers to Service Access and Support in Tameside

In reviewing the data from services the AVA team noted a lack of self-referrals to most services. Also notable was the high percentage of referrals that came from the police and significantly low numbers of referrals from health services.

The AVA team wanted to understand the survivor's perspective on what the barriers were to asking for or seeking support. A significant theme was a lack of understanding of the full range of Coercive and Controlling Behaviours (CCB). We highlight this given that it is a strengthened area in the new domestic abuse Act. This understanding seems to be limiting survivors' own labelling of the perpetrators behaviour as abusive and consequently seeking support.

Survivors also told us about other barriers:

- 58.8% strongly agreed that they were worried about the consequences from the perpetrator or the services they approached.

- 47.1% agreed or strongly agreed that they didn't know where to go for help and support.

"I approached Bridges first, about 3 yrs ago. Don't know how I became aware of them I think my advocate put me on to them. It's hard to access services as a man, you don't feel like doing it and it feels like nothing will work anyway".
Survivor interview

Survivors described the fear of the unknown being a big source of anxiety:

"A big fear is that you have to move, it's a big national thing, I didn't want to relocate, that's going to put women off getting that help. You have all those worries and fears before you get help."
Survivor interview

In line with national research women survivors in particular identified a fear of what would happen to their children as a significant barrier for help seeking:

"One of the big things I was worried about was social services, am I going to have them sniffing round, how is this going to affect them? My kid used to have night terrors and one of the neighbours called social services on us and they investigated – it was shut down straight away and we did get a little bit of help but I was worried that social services would stop him seeing the kids, or would he have to have supervised visits, it made me think about what's going to impact on the kids, and would I still be able to work? My partner had a good job and he earnt more money than me – would they look at us and look at me and say I can't support them, he looks better than me on paper – he's already got a house, it reinforces the feelings that you've got about what's going to happen to them."
Survivor interview

Staying Local

As identified above victim-survivors expressed a strong desire to stay local, to continue to be part of their community and to preserve relationships with friends and family and maintain their employment;

"For me I really need the people close to me, I rely on them massively, they know me so well, and we go and grab a coffee if I'm having a bad day. Without that I don't think I would have been able to get through it. As good as the refuge were there were times you just need your friends. It was really hard, Covid made everything worse, but because it was local I had those little moments I knew when I took my kids to school I'd be able to see familiar faces who knew me and knew I was alright."
Survivor interview

"Bridges gave me a few days to think about it – but I had no other option so I went into the local refuge – it weren't far at all. It made it easier that it was close, it felt like we could keep some normality a bit. It was a hassle but the kids could stay at school and he [son] had that part of his life that stayed the same. I felt like he benefited from that. He had his support network, teachers and friends, I'd told the teachers from the start that I was in touch with Bridges and stuff to make them aware of how he might struggle. Refuge got in touch with the school and the school rang me and went through a couple of things. Even stuff like being able to see Dad helped, they go to his at the weekends. If it had been the other side of Manchester it would have been impossible".

Survivor interview

"Being local meant I could still work, for me that meant I had a bit of normality. Work were really supportive when I told them. It was a good thing for me. I was able to still be me, no one knows, I had a little wellness plan – flexibility for going off and talking to people, managers knew and I could to talk to them if I was having a bad day. If it had been miles away I would have had no support, I'd have had nothing."

Survivor interview

Local Point of Excellence:
Tameside provides a holistic service model that supports victim-survivors to stay connected with their local roots and increases their choice and space for action.

2.4 The Tameside Victim-survivor Specialist Service Offer

Tameside has a range of commissioned and non-commissioned voluntary sector services which provide a flexible options for support and access for victim-survivors. We believe it is best practice in local provision to protect a strong community footprint of voluntary sector agencies that can provide a mix of referral sources and a tailored offer which can respond to the needs of victim-survivors.

2.4.1 Bridges

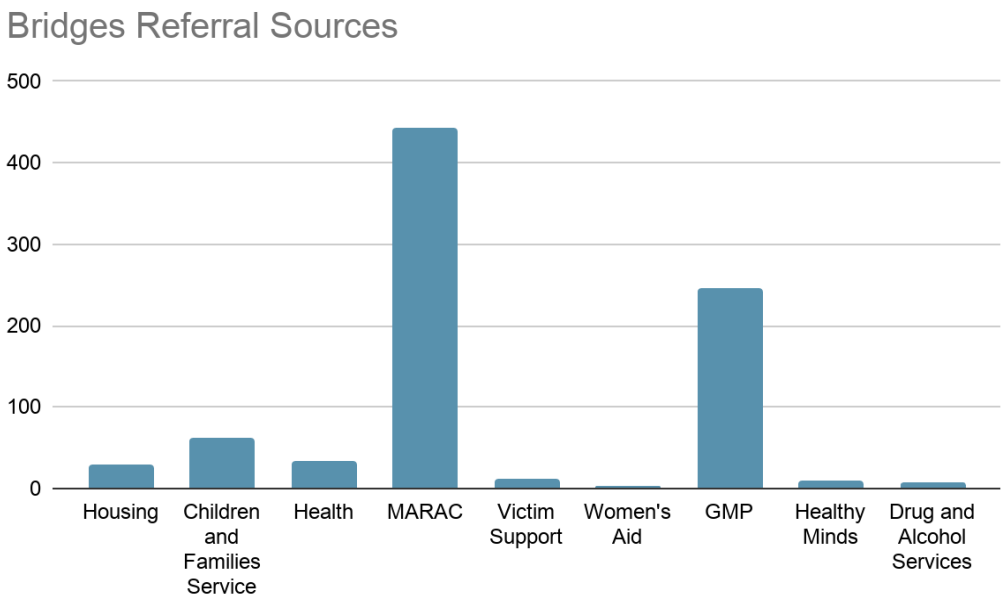
Bridges is the commissioned domestic abuse service for Tameside. It is a well-established and well-valued service noted by professionals for the training and ad hoc support it provides to help them meet the needs of survivors in the area. It holds Leading Lights accreditation for its IDVA services.

The IDVA team is supported by a service model that supports male and female survivors across the risk levels. Bridges provide specialist children's services in the form of their

CHIDVA service and dedicated women only refuge provision, dispersed accommodation and sanctuary schemes to meet victim-survivors housing needs.

Bridges receives approximately 1000 referrals each year, these referrals come from a range of services in Tameside but predominantly the MARAC and the Police.

Table 1: referral sources for Bridges – performance data 2020/21



In the year we were supplied with data there were 8 referrals in the 'other' category – this is where self-referrals are counted.

Data Recommendation:

- Self-referral is a good indicator of early intervention and requires its own category in the Bridges data set.
- self-referrals should be monitored as an indicator of success in future public awareness campaigns.

2.4.1.1 Profile of Victim-survivors Using Bridges

Bridges routinely collects data on the demographics of the residents using its services. Bridges uses the following categories for its demographic breakdown:

- British
- Other Ethnic Group
- Other White
- White and Black Caribbean
- White and Asian
- Other Mixed
- Indian
- Pakistani
- Bangladeshi
- Other Asian
- Caribbean
- African
- Other Chinese
- Polish
- Refused to share.

Categories on collecting Race and Ethnicity are often problematic; an attempt to standardise a uniquely personal experience. The Bridges data does not catch specific data on White British identity. There is no data point for residents that come from the Middle East – this is significant because 16% of all asylum claims granted in England were for Iranian residents, and 28% were Syrian nationals. The category listing 'African' heritage could be making differences invisible given that 1% of those granted asylum were originally from

Data Recommendations:

- Bridges should collect data on race and ethnicity in line with census categories.
- Bridges should collect data on immigration status, asylum status and the entitlement to public funds of its client group.
- Bridges should check that clients from particular race/ethnic backgrounds are not over represented in the disengagement/closed cases.

Eritrea and 17% from Sudan.[16]

[16] How many people do we grant asylum or protection to? - GOV.UK (www.gov.uk)

Bridges work with majority of women victim-survivors. 96.3% of its beneficiaries are women and 3.7% men – there is no data for non-binary people. This breakdown demonstrates a slight under representation of male victim-survivors. The ONS statistics on domestic abuse profile across England and Wales[17] has a recorded 5% as male victim-survivors and the national IDVA data set records 4% of male victims.

Bridges shows a good level of engagement across the age spectrum. We have been able to provide rough comparisons across different national data sets, but the lack of consistency in age categories makes direct comparisons difficult.

A lack of consistency makes understanding engagement patterns of older clients more difficult.

Data Recommendation:

- Bridges data on age should be collected in line with national comparator age brackets.
- Trends for engagement patterns with older victims should be monitored.

Table 2: age profile of Bridges clients – data from 2019/20

	Bridges Data	WA National Data set Community and Refuge	SL IDVA Dataset Community only
Under 18	3% (n 26)	5% (0 – 20)	1% (0-16)
18 – 25 yrs old	18% (n 181)	13% (21 – 25)	6% (16 – 20)
26 – 34 yrs old	39% (n 391)	17% (26 – 30)	37% (21 – 30)
		18% (31 – 35)	
35 – 44 yrs old	24% (n 243)	16% (36 – 40)	31% (31 – 40)
		11% (41 -45)	
45 – 54 yrs old	9% (n 90)	7% (46 – 50)	16% (41 – 50)
		4% (51 – 55)	

[17]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimservicesenglandandwales/november2020

55 – 64 yrs old	3% (n37)	3% (56 – 60)	6% (51 – 60)
		1% (61 – 65)	
64+	1% (n17)	5% (65+)	3% (60+)

Other patterns in the Bridges data of note is that 95% of the cohort are not disabled and 90% of the cohort identify as heterosexual.

2.4.1.2 Survivors Perceptions of Bridges

"I wanted a local service, definitely Bridges over Women's Aid. I felt as well because I wasn't sure, I felt like I just wanted someone who in my opinion would know more about it. I didn't feel like it was serious enough to contact the police, I didn't want to waste anyone's time, they are busy enough as it is. It could have been nothing. I didn't want to feel like I was bugging anyone. I was trying to understand it a little bit more."

Survivor interview

"At first it was useful to have reassurance that things weren't right and that my gut instinct wasn't right, it felt like they helped me put things together. We talked about refuge but that was a last resort – that was the last thing I wanted. I just wanted to find somewhere else to live and they were going to help me with that."

Survivor interview

"Bridges are a godsend, they really did and are still helping me understand my abuse and how to take the next step. I do think there should be more surrounding when your abuser gets arrested though and what to expect."

Quote from survey respondent

"Bridges has been very supportive and helped me a lot dealing with domestic abuse and offered mental health help, the freedom programme and also legal aid through a solicitor. I think this is a very important issue that needs to be funded."

Quote from survey respondent

"I was discharged from the Tameside service much too soon, because there was apparently no continuing abuse. That does not reflect a good understanding of how abuse operates- it doesn't just stop because a relationship ends, and more to the point, the psychological and emotional damage caused doesn't just suddenly reverse, which leaves a woman very vulnerable to returning to the abusive relationship, or entering into another controlling

dynamic because they haven't had the help to understanding the dynamics at plan and have proper help with self-worth and self-esteem."

Survivor Survey response

2.4.2 General Victim Support in Tameside

Generalist Victim Support in Tameside is funded by the Greater Manchester Mayor's Office and the Tameside council website links through to the main Victim Support website. We weren't able to assess how many referrals were made to Victim Support from Tameside Residents and what proportion of these related to current or historic domestic abuse.

Victim Support is a support service offering support to 'multi-crime' victims. In an average week across England and Wales they receive 15,300 referrals, taking in self referrals and referrals from police. As a result of lockdown across England they report a 23% increase in the number of victim-survivors reaching out to them for domestic abuse, an additional 640 victims a week. The majority of these (93%) are classed as medium/standard risk.[18] In one year they referred just 12 clients to Bridges. It is possible that victim-survivors who are self-referring are doing so to Victim Support or another more specialist helpline and not being referred to a local offer.

2.4.3 Diversity Matters North West

Diversity Matters North West is an independent charity in Tameside. They receive grant funding from Comic Relief for their 'Women Supporting Women' project with women in Tameside who have South Asian heritage. Their local knowledge on domestic abuse needs of this under-served cohort is shared with local operational groups, and other services for Black and Minoritised women in Greater Manchester. They are a strong local resource acting as a gateway for women to statutory service offers. They work closely with CCG colleagues to help identify the barriers for women with South Asian heritage in accessing mental health services and have worked closely with emerging domestic abuse governance infrastructure.

Their women beneficiaries are under-represented in both MARAC and in general domestic abuse data.

In 2019/20 they worked with:

- 148 Individual Women from South Asian Communities providing 28 women with 1:1 support.

[18]https://www.victimsupport.org.uk/wp-content/uploads/2021/03/2020_Crime_and_Covid19_Impact_report.pdf

Alongside their direct health and well-being outcomes the 'Women Supporting Women' project creates a network of support for women and creates safe and culturally appropriate ways to discuss domestic abuse with Tameside residents who have South Asian heritage. This community based early intervention approach is known to be effective for reaching women at increased risk of domestic abuse:

- 95% (of women worked with) advised an increased awareness of domestic abuse.
- 93% advised an increased awareness of support services. This project has seen referrals and women sign posted to organisations such as Mind, Tameside ACE, Health and Wellbeing college, Manchester Immigration Aid, Saheli, Local solicitors, children's centres, Be Well Tameside.

Local Point of Excellence:
A specialist community development model for South Asian Women offering culturally appropriate community-based education which increases awareness of domestic abuse and challenges tolerance of the attitudes that contribute to it.

DMNW carried out a focus group with their beneficiaries on the overlaps between domestic abuse and mental health for their women in their communities. Women asked for more community-based interventions specifically for women of South Asian heritage. They noted how important it was for it to be co-delivered by and for the women it was targeting.

The same attitudes found in the general Tameside population about domestic abuse being a physical issue are found with residents with a South Asian heritage:

"I didn't know before that domestic abuse is not only hitting someone, it's a lot more than I knew."

DMNW Focus Group participant 2020

2.4.4 Women and Families Centre

The Women and Families Centre is a strong voluntary sector offer providing access and wrap around holistic support to women and families. It provides a mix of 1:1 work, a flexible group work programme covering a range of support and achieves an impressive mix of outcomes for the 310 women referred to the centre each year. The majority are white (90%) and over 40% are disabled, they range in age from 16 – 64 and 45% receive support for domestic abuse related issues. Their referral sources are varied – taking in referrals from MARAC, refuge, health care services. It is likely that the majority of the women supported through the Women and Families Centre are represented in other data sets.

Local Point of Excellence:
A specialist women led community hub providing dedicated services for marginalised women. It provides significant social return on investment enabling women meet outcomes of significant value to both themselves and the state. It serves as an important access point to domestic abuse victim-survivors who otherwise would not access multi-agency services or CJS agencies.

Case Study – No Recourse to Public Funds

"S has three children and presented to the Women and Families Centre by knocking on the door on a Friday afternoon asking "please, can anyone help me?" She managed to tell staff that her husband was emotionally and psychologically abusive and that she had concerns about his behaviour towards their teenage daughter. The husband controlled money and finances and limited S's contact with her friends and support network. S didn't want to go home but was concerned about how to get her children from the home. The Women and Families Centre called for the police and social services. S has no recourse to public funds. The Women and Families Centre contacted the home office who started to make arrangements for her to be taken to an immigration shelter in Liverpool with her children. At the point when the driver arrived to take her to the immigration shelter her younger children were still with the perpetrator and so she refused to leave the Women and Families Centre. At 7.45 staff at the Women and Families Centre began to make emergency accommodation arrangements for her and her elder daughter, they were housed at 11.30 and provided with food and vouchers from the Women and Families Centre. On the Monday S and her daughter returned to the centre for 1:1 support. Staff began working across housing associations, social services and immigration to find a way forward for them, out of emergency accommodation. The preferred option was to remove the perpetrator from the property and secure it through sanctuary services. When the police went to interview the perpetrator S was able to collect the younger children from school, they were reunited at the women's centre at 6pm on the Monday evening. The police contacted the Centre to let S know that they had removed the perpetrator from the property and they were safe to return. S was offered 1:1 weekly support from the Women and Families centre, a referral to the Bridges for DA support, she attended group work programmes that increased her understanding of domestic abuse and increased her skills around emotional well-being."

Case Study - The Needs of a Woman who had Children Removed

J is a 36 year old White British female who has had first child removed. She was motivated to self-refer to the Women and Families Centre when her second child was born in an attempt to keep her child with her. A Child Protection Plan was put in place for the new baby and J worked hard with the service.

J had a range of lived experience of Multiple Disadvantage, she had experienced domestic abuse, struggled with substance use, had strong mental health needs and used self-injury to manage difficult feelings.

J accessed a range of support from the Women and Families Centre, 1:1 and group work and dedicated mental health offers. After a year of hard work the CPP was reduced to CIN. Within 3 months there were no longer any plans and gradually J stopped attending and we did not see J or her child for approx. 4 years.

Just before the lockdown J re-presented at the Women's Centre returning from another borough. Her child had been placed back on a CPP and she wanted support from the centre to recover from a domestic abuse relationship. J was placed in the Tameside refuge, increasing her physical safety but while her physical safety increased her emotional safety lessened, she was very scared due to what had happened before and was frightened of losing her child. The Women's Centre put a full support plan into place working closely with CSC and advocating for J. The Women's Centre provided referrals to the Mental Health team independent living support through budgeting and life skills and parenting courses. The Women's Center worked at a pace J could manage and slowly her confidence and sense of safety improved. J was moved from the refuge into temporary accommodation where she met a new partner. Life was settled for a while until someone broke into the flat and she noticed her partner had 'changed'. The Women and Families Centre worker completed a Claire's Law disclosure with J which revealed a serial domestic abuse perpetrator. J was pregnant again and due to the information about her current partner CSC decided to increase from CPP to PLO. J tried her best to keep her pregnancy from her partner but he found out and threats started against her. The Women and Families Centre staff knew that in order to help J feel and be safe a move from temporary accommodation back into refuge wasn't the best move for her. They worked hard with housing colleagues to find her a secure permanent home, it took more than two weeks of advocating and hard work but she was housed in a property. The PLO has been stepped down due to the hard work of J and the team around her at the Women and Families Centre. Children's Social Care can see the steps that J has taken to safeguard herself, her child and unborn child. The new property was secured through the Sanctuary scheme through a referral to Bridges, J is now abstinent, learning to read and write and has completed a positive pre-birth assessment. She is looking

forward to the birth of her second child and remains in contact with peer support and other groups at the Women and Families center. ”

2.4.5 Local Money Advice Services – Voluntary Sector and Other

The AVA team observed the lack of referrals between CAB, DWP and other benefits support services. Given the high socio-economic need in Tameside there is a large probability that victim-survivors are seeking support for benefits advice and advice around increasing economic freedom.

The new Domestic Abuse Act extends the understanding of economic and financial abuse and patterns of restrictions and withholding economic resources as part of a pattern of coercive and controlling behaviours and going forward data should be collected on these needs to ensure that Tameside is meeting its duties under the new legislation.

Data Recommendations:

- Tameside should collect data on the socio-economic needs of victim-survivors, as distinct from socio-economic status.
- Tameside should create a KPI on assessing performance of key benefits agencies on identification and responding to the needs of victim-survivors.
- Citizen's Advice Bureau should be invited to provide annual data on the numbers of victim-survivors identified in their service and what percentage this is of their total caseload.
- DWP and other statutory benefits support services should provide annual data on the numbers of victim-survivors identified as part of their routine work.

Practice Recommendations:

- Tameside should investigate whether local CAB would benefit from being part of the national CAB programme on GBV and DA routine enquiry to better support identification of victim-survivors requiring money advice and benefit support.
- Surviving Economic Abuse have a range of training offers that might support local practitioners in identification of barriers to economic freedom.

Chapter Three:
Understanding Housing Needs

The Act places a duty on local authorities in England to: provide support to victim/survivors and their children in refuges and other safe accommodation; to ensure victims of domestic abuse do not lose a secure lifetime or assured tenancy; and that all eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance.

Orientation

Victim-survivors tell us that their number one priority is a safe place to live, for both themselves and their children. It gives a sense of security and real world safety and an ability to 'move on'. At the point of crisis and leaving the relationship most victim-survivors want either their perpetrator removed from the property or a new home. Domestic abuse is the largest cause of women's homelessness in the UK.[19]

3.1 Local Data on Homelessness

In Tameside during April 2019 to March 2020 757 cases triggered a homeless application, of which 107 cases recorded domestic abuse main reason for loss of settled accommodation. This accounts for 14% of all homeless applications in that year. This is higher than the government statistics that suggest 10% of applications for homelessness is due to domestic abuse.[20] 48 of these cases had children but there are no records kept of the number of children or their needs. 59 were single homeless applications. There is no demographic detail available for the residents making homelessness applications. A substantial gap in the data lies in the fact that no records are kept of the protected characteristics of these homelessness applications. This is important because women are both disproportionately affected by domestic abuse and often 'hidden' from official homelessness statistics. Homelessness charity St. Mungo's report that 32% of the women they work with, and 8% of men, said domestic abuse contributed to their homelessness.

[19] guide-to-domestic-violence-housing-and-homelessness.pdf (rightsofwomen.org.uk)
Chapter 21: Domestic abuse - Homelessness code of guidance for local authorities - Guidance - GOV.UK (www.gov.uk)
[20] https://safelives.org.uk/sites/default/files/resources/Safe_at_home_Spotlight_web.pdf

3.1.2 Tameside Housing and Affordability

Table 3 – key housing need indicators for Tameside, England and closest statistical neighbours using MHCLG published data for 2017/18

	Housing		
	(2016) Housing affordability ratio	(2017/18) Statutory homelessness - households in temporary accommodation	(2017/18) Statutory homelessness: eligible homeless people not in priority need
England	**7.2**	**3.4**	**0.8**
Tameside	**5.3**	**1.1**	**1.7**
Rotherham	**5.3**	**No data**	**0.3**
Doncaster	**5.1**	**0.3**	**0.7**
St. Helens	**4.4**	**0.2**	**0.1**

It shows us that housing affordability in Tameside is lower than the national average. Despite this apparent 'affordability' survivors still told us that access to private rented accommodation was incredibly difficult. Landlords of private rented sector (PRS) accommodation showed discriminatory attitudes to housing those reliant on benefits so 'affordability' should be approached with caution.

"I tried everything to find somewhere else to live. I went round the local estate agents, I made myself aware of what they can and can't do. I got advice from Shelter. I enquired about a couple of houses and the estate agent really put my case forward. I'd got the bond and I was willing to do the guarantor thing, I was willing to put down a bigger deposit, pay a bit more rent. There were a couple (private landlords) that just wouldn't accept me because I had benefits. My friend knew a few landlords and they rang round for me – but no one was being evicted or had any vacancies. The things that were available were so highly sort after that landlords could be really fussy. I spoke to Tameside Housing – they gave me lists of housing associations to put my name down on and told me to try and find somewhere private. It felt like there was nothing much anyone could do before I was in refuge because I was classed as being 'housed' there was no urgency. The Landlords blanket rule about housing benefit felt really unfair."

Survivor interview

"The biggest barrier for me was accessing housing – there needs to be more help with making exceptions, I always felt grateful for social housing, as long as I pay my rent I know I'm safe. I'm glad I'm not in private renting but I do think it should be harder for landlords to say no to survivors of domestic abuse. I don't think you should be allowed to say 'no'. I think there should be local authority scheme or something to help. I wouldn't have had to go to refuge if I could have found somewhere to live – there would have been more space there. There would have been a room for someone else. I couldn't get anywhere but refuge when I needed to leave and I was in refuge for too long. Housing has such an impact on your quality of life, as time went on it was harder [living in refuge], it was becoming really difficult for the kids, there were more questions – why are there no men allowed in here, there's a lot that could have been avoided if there was something that could have just helped me out. The council need to do something – pressure applied to landlords to make sure they take on domestic abuse survivors. There are women in refuge who have been in there for over a year because they are just waiting for somewhere to live. All that could have been avoided. We need to find a way to get access to housing easier, then you can take out these women who don't need it – the only reason I was there is because I couldn't access the housing. It adds pressure where you don't need it."

Survivor interview

While statutory homelessness rates in Tameside are lower than the national average the differences between Tameside and its closest statistical neighbours do not bear substantial significance.

3.1.3 Local and Statistical Neighbours Data on Temporary Accommodation

Although Tameside has a lower number of homelessness households in temporary accommodation than the English average it is significantly higher than those of its nearest statistical neighbours. The use of temporary accommodation in Tameside was identified by housing professionals and victim-survivors as problematic.

In interviews housing staff talked about wanting a range of housing options that could give survivors the 'breathing space' to make up their mind and assess housing options available to them. This breathing space is what temporary accommodation is designed to do and yet for many staff and survivors the provision available is not meeting that local need.

Survivors noted that not wanting to be in temporary accommodation was a barrier to help seeking, they noted the length of time that they might be in temporary accommodation and they questioned the safety of the offer. Frontline staff in housing discussed families that were accommodated in temporary accommodation and B&B's for up to six weeks.

Survivors talk about being asked to stay with friends and family members first to avoid temporary accommodation. Table 5 demonstrates that 10% of all survivors accessing Bridges were staying with friends and families.

"I know the housing situation is terrible everywhere, if someone needed to flee immediately we need to be honest we tell them that there are no empty properties anywhere. No one has a property waiting for tenants. While people ***should be*** *offered temporary accommodation they are told to look for a place with family first. They stay on friend's sofa, and then the first thing Housing Options will do is ask the friend to keep her longer. It's about reducing the use of temporary accommodation but then victim-survivors just end up at the back of the housing queue."*

Local IDVA interview

"B&B's and Hostels aren't appropriate for victims of domestic abuse, they aren't secure, they aren't restricted to women or victims of abuse, there's no support staff or recording who goes in and out. They don't feel safe. It's the victim who has to leave that suffers more than the perpetrator."

Housing staff interview

This type of housing is not regarded as 'safe accommodation' under the Domestic Abuse Act guidance. The new guidance accompanying the Act recommends a case by case approach to understanding which housing option is appropriate for which victim. This needs to include a full understanding of their circumstances and needs. The guidance suggests that temporary accommodation whilst action is taken to exclude, arrest or detain a perpetrator is a suitable use of temporary accommodation. Use of temporary accommodation while other opportunities are identified to make victim's homes safer and to give housing staff time to work with MARAC in other multi-agency forums to reduce risk of further harm are also identified as good use of temporary accommodation.

Practice Recommendation:

- The use of temporary accommodation in Tameside for domestic abuse survivors should be reviewed and changes in allocation should be prioritised to ensure use in line with the new guidance.
- Housing staff wanted to offer trauma informed support to victim-survivors with survivors being offered appoints with housing officers in their own home/safe venues and more flexibility offered to survivors who had declined housing offers before .
- Workforce development and training to support housing staff in carrying out DASH risk or other standardised domestic abuse assessments with clients to support the risk posed by the perpetrator this should inform the housing solutions they offer to victim-survivors.
- Publicity and communications should be targeted at private landlords to encourage them to make their property available to domestic abuse victim-survivors.

Table 4 re-produces data from the UK Statutory Homelessness statistics (2019-20) provides greater insight into the domestic abuse needs in Tameside.

Table 4: data from UK statutory homelessness statistics from 2019/20 published by MHCLG

	Domestic abuse as reason for loss of last settled home for households owed a prevention duty:		Domestic abuse as reason for loss of last settled home for households owed a relief duty:		Domestic abuse as support needs of households owed a prevention or relief duty:	
	Number	*Percentage*	Number	*Percentage*	Number	*Percentage*
England	**9,030**	***6.10%***	**17,550**	***12.60%***	**26,790**	***9.30%***
Tameside	**42**	***6.10%***	**64**	***9.70%***	**94**	***7.00%***
Rotherham	**44**	***7.30%***	**173**	***14.60%***	**120**	***6.70%***
Doncaster	**42**	***7.40%***	**179**	***15.10%***	**251**	***14.30%***
St Helen's	**30**	***5.40%***	**21**	***6.80%***	**44**	***5.10%***

These statistics provide a better breakdown relating to statutory homelessness directly linked with domestic abuse. These statistics highlight Tameside's similar rate in domestic abuse as a reason for a household being owed a prevention duty to both its statistical neighbours and the national average.

In terms of relief duty and households where domestic abuse is identified as a support need, we see Tameside sits below the national average, but at an average rate in comparison to its statistical neighbours.

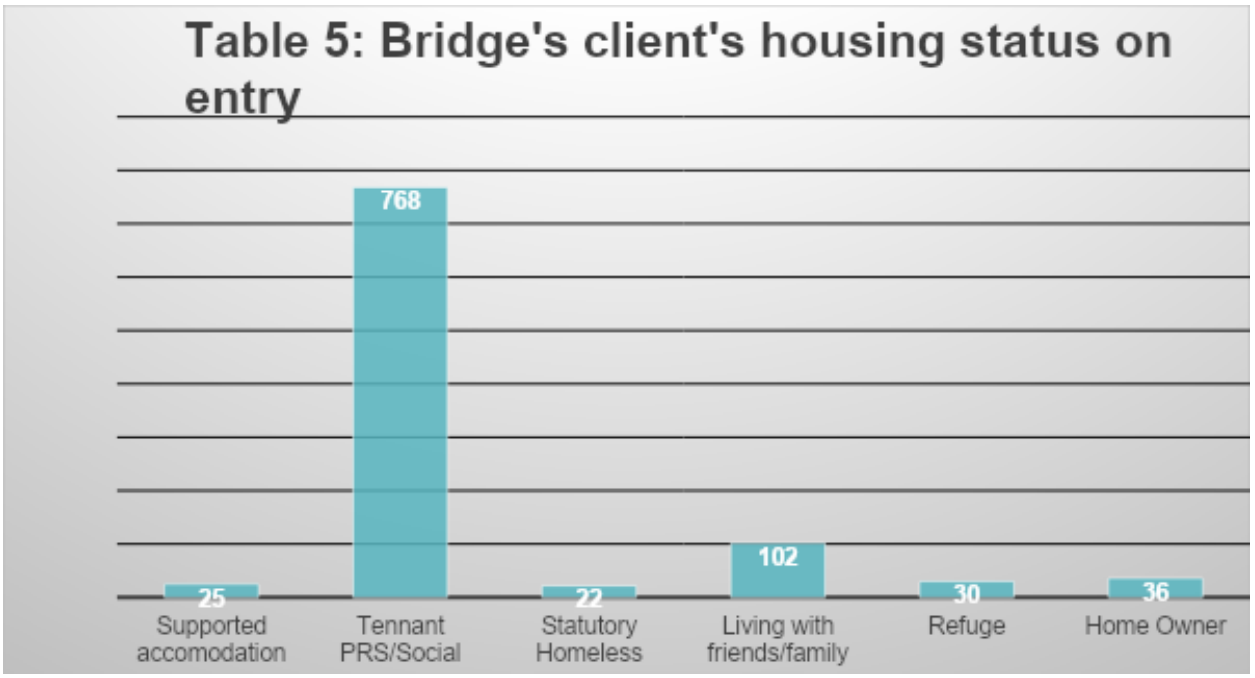
Local Data Recommendation:

- Housing teams should collect data on the demographics of residents making homelessness applications.
- Housing teams should collect data on the demographics of children identified as homeless through a parent.
- Housing teams should collect specific data on the numbers of 16 – 18 year olds presenting as homelessness.
- Capturing data within the framework set out by MHCLG in their statutory homelessness live tables would allow more ready comparison across England and closes statistical neighbours.

3.1.4 Other Data on Housing Need

Bridges collects data on the housing needs of its clients on entry, providing an insight into the housing needs of victim-survivors of domestic abuse. The vast majority of Bridges clients are housed in the PRS or Social Housing.

Table 5: Bridges performance data collected by Tameside Metropolitan Borough Council for 2020/21



There is no breakdown in the data to differentiate between those in private rented accommodation or social housing. This is likely to make it difficult to manage the new responsibility to protect victim-survivors social tenancy.

Local Data Recommendation:

- Bridges should capture data on victim-survivors tenancy type to check for performance against the new protections for victim-survivors.

3.2. Interviews with Housing Staff

3.2.1 Identification

The housing guidance that accompanies the new Domestic Abuse Act requires local authorities to develop a strong understanding of domestic abuse, the context it takes place in and the impact on different groups. It suggests that specialist training for staff and managers takes place to ensure that they provide a sensitive response, identify need, and focus only on housing options which are safe and appropriate for victim needs. Staff

reported in interviews that they felt confident identifying domestic abuse but survivors reported that the housing options team had limited understanding of the housing solutions available to domestic abuse survivors and the protections they were entitled to:

"I got told by housing that because I was a man I didn't qualify for anything, I'd have to sleep on the street, I went on the council housing list and bid for two and a half years and then I got told I couldn't have a place because there was too much equity. They believed me but told me there was nothing they could do because I was a single male, if it wasn't for my mum I'd have been on the streets. I doubt I'd have been here if I'd have had to do that."

Male survivor interview

"All your life you think if you're a good person it counts for something but at the point you need support it counts for nothing. If you can't leave how are you meant to have a fresh start? We're all working for a better life but no one is willing to give you a chance – I did everything I could think of but it just wasn't enough. It feels so unfair. You're destined to fail. Tameside Housing let me down - they didn't ask about domestic abuse, even though I was working with Bridges already and so in their eyes because I worked and had a deposit they thought I just needed to get lucky and find a landlord. There was nothing else they could do for me. I was already getting the help from Bridges – to them everything was in place and there was nothing I could do."

Female survivor interview

3.2.2 Meeting Needs and Finding Outcomes Data

We asked staff working across Tameside housing teams how they knew they had met the needs of survivors. A range of views were offered, the most visual being a wall of thank you cards from individuals they had helped in the office. Others talked about how housing legislation had created a culture of rules and they had lost sight of the outcomes aside from a physical roof over someone's head.

Practice Recommendation:

- Additional training and workforce development should be provided for housing staff on identification of survivors.
- Up to date information for housing staff on the housing pathway for survivors that gives housing staff the flexibility to build case-by-case housing solutions for victim-survivors informed by needs and risk management.
- Tameside Housing staff would welcome an outcomes focused culture which monitors customer satisfaction and is led by the client's measure of success.
- A joined up offer of support across multiple teams to help survivors with complex and multiple needs to maintain tenancies.

3.3 Non-housing Staff Interviews

Interviews with staff responsible for supporting survivors revealed low levels of understanding on housing obligations and the needs of victim-survivors. All professionals we talked to identified a lack of social housing in Tameside as an issue for securing accommodation for victim-survivors.

Some professionals wondered if domestic abuse was being used by some people to get access to housing they weren't entitled to. We predict that when housing staff are better resourced to do more dedicated support for victim-survivors it will build confidence across the system in housing staff's ability to correctly identify victim-survivors. These attitudes are illustrated through the following quotes from an interview with non-housing staff:

> *"Housing is really hard – I have spent hours trying to get people on the housing register, the victims are losing out. They've done so much to get free of the perpetrator but they can't be housed. Social housing is so scarce. We'd all like a better house – but we're seeing increases in people who are using domestic abuse as a reason to get housing but who aren't 'genuine' victims. It's difficult to decide who is in housing need – especially with large homeless populations. You need to get those who need to move because the perp won't leave them alone. It is an issue – but not for everyone".*
>
> ***Non-housing specialist staff interview***

In this quote the staff member is incorrect about domestic abuse survivors rights in relation to housing:

> *"Housing is a horrible situation, if you choose to leave you lose your duty to be housed."*
>
> ***Interview with non-housing specialist staff member***

Interviews also illustrated the need for more flexibility with regard to understanding financial abuse, coerced debt and access to property:

> *"it's hard if you've got capital in a property."*
>
> ***Interview with non-housing specialist staff member***

Practice Recommendation:

- All frontline facing staff should receive up to date training on the new duties and housing rights of domestic abuse victim-survivors.
- Up to date information for frontline workers on the local housing pathway should be produced to increase the ability of frontline staff to advocate for victim-survivors.

Data Recommendation:

- Housing team should monitor performance against outcomes, including whether survivors felt believed and listened to by housing staff.
- Outcomes monitoring should be standardised across services to ensure that services have collective accountability for outcomes for victims and their children.
- KPI for housing teams should include accessibility markers including whether clients were offered a choice of gender in their housing support worker.
- KPIs for housing teams should include where housing support was offered, and monitoring on the length of time individual advice sessions are.

3.4 Housing and MARAC

The guidance that accompanies the new Domestic Abuse Act makes clear the responsibility of housing authorities in identifying victim-survivors and referring them for help and support. The importance of housing in safety and recovery makes housing authorities key partners in local domestic violence partnerships and as such the guidance makes clear that they should be represented at MARACs.

At present housing does not attend MARACs, there is a low level of referrals from housing to MARAC and housing support workers are not routinely doing the DASH with victim-survivors. In practice this means that it can fall to other professionals who do attend the MARAC to respond to housing need and advocate on behalf of victim-survivors. Some professionals in interviews highlighted the gap in leadership that was created by the lack of housing attendance and how housing staff suffered from the lack of insights into local need and survivor need that is generated through MARAC.

Practice Recommendation:

- Training should be provided to housing staff on the MARAC and its local function to encourage trusting referrals to be made between housing and MARAC.
- A member of staff with responsibility for housing should be regularly present at MARAC, they should hold a position which affords them the ability to make key decision, agree actions, and ensure these actions are carried out on behalf of their agency. The relevant participants must be able to agree funding decisions or have direct access to a manager to allow quick funding decision to be made.

Data Recommendation:

- MARAC Performance data should track changes in referrals from housing teams as a result of training and investment in referral pathway development.
- Housing should track the numbers of assessments of high risk domestic abuse in homelessness applications.
- Housing teams should disaggregate their domestic abuse data to check for progress against support victim-survivors before the point of crisis.

3.5 Service Offers Relating to Housing Needs

3.5.1 Refuge

Alongside the statutory housing offer made to domestic abuse victim-survivors through universal housing services there are particular temporary housing options widely held as essential domestic abuse services. The national network of refuges was built in the 1970's and 80's by feminists advocating for better solutions to the issue of domestic abuse and remains an essential feature of local and national service provision.

"Refuge has provided me with structure and stability."
Survivor refuge focus group

Refuges are not just a roof over someone's head, they are a complex support service where physical and psychological safety are built for women and children. Teaming emotional support, recovery services and accommodation provides a uniquely empowering experience outside of the normal 'hierarchy' of service provision as illustrated by this quote from a current refuge resident:

"I didn't even know (blank) was the manager when I first met her, she was so warm and empathetic"
Current refuge resident

The new guidelines that accompany the Domestic Abuse Act sets out the uniqueness of a refuge service offer:

"For victims at risk from highly dangerous perpetrators, refuges will usually be the most appropriate choice. Refuges provide key short term, intensive support for those who flee from abuse. Given the intensity of the support and the vulnerability of the victims, attention should be paid to the length of time they spend in a refuge. Refuges are not simply a substitute for other forms of temporary accommodation. The housing authority should work with the refuge provider to consider how long a person needs to stay before the provision of other accommodation (which may be temporary in the absence of settled accommodation) may be more appropriate, potentially with floating support if needed."

Refuge Case Study

"A is a White British woman in her mid-40s. She has children who have been removed from her care, her youngest child is 16, is living with family. She also has grandchildren. A self-referred into refuge after 11 years of abuse. She has historically been a heavy substance user. A had experienced such severe physical domestic abuse that she was put in a coma, she says the biggest turning point for her was a doctor pleading with her to get help, 'for goodness sake, your injuries are so bad you look like you've been hit by a bus'.

A comes from a family local to Tameside, though she also had been living in the Northwest outside of GM when she self-referred in. She used to live in Stockport, which is where her children were removed into local authority care due to her drug use. Her experience of police had been negative. She felt that police officers did not have much empathy for her situation particularly because of her substance misuse and felt like she was trouble.

She had been in refuge before, but didn't feel the move on support was good. She felt alone and had no support network, which meant she relapsed 'into my old ways' and back into bad relationships. 'You need a good network around you before you're put into your next property after the refuge'.

A reflected on some of her behaviour in the past, particularly how she treated her children. 'I let myself down too', she was scared to be a 'grass' and report her abuser. There was also a fear that if she did, then 'social would be poking in my business and everyone would think

I'm a grass'. A feels she is at a turning point now and can see herself on the road to recovery, when asked what she'd like to do in the future she discussed the possibility of volunteering to help women like herself and getting involved in the women's sector. ”

3.5.1.1 Child Victims in Refuge

Children living in refuge have particular needs and are often overlooked refuge residents, nationally 62.5% of women in refuge have children and 8% of refuge residents are pregnant.[21]

The Tameside flexible refuge offer also supports them to meet the variety of resident's needs. Refuge spaces for men, and LGBT people are provided through separate self-contained units with support provided by floating support.

Local Point of Excellence:
A key strength of the Tameside refuge offer is the flexibility of the refuge service offer and its particular care of child residents. In Tameside children in refuge are offered both 1:1 support and group work in order to recover from their experiences living with a domestic abuse perpetrator, a strong addition to the Tameside support offer.

3.5.1.2 Women Only Refuge Spaces

There are 17 units available for women and children in Tameside able to accommodate up to 20 children.

The Council of Europe recommends that there is one family place in a refuge per 10,000 of the population. In Tameside this would equate to 26.6 units. This suggests a deficit of 9.6 refuge units. Bridges staff tell us that 'refuge is always full'.

Practice Recommendation:

- To invest in women only refuge provision to increase provision to Council of Europe recommended level.

3.5.1.3 Understanding Local Use of Refuge Service

There is a strong desire for those seeking refuge in Tameside to 'stay local'. Strong community ties, strong relationships with services make leaving the area hard for residents.

[21]https://www.womensaid.org.uk/wp-content/uploads/2021/01/The-Domestic-Abuse-Report-2021-The-Annual-Audit.pdf

Leaving the community for refuge makes isolation more intense and reduces space for long term recovery.

Refuge is a heart for services with strong relationships with both the voluntary and statutory sectors in Tameside. Diversity Matters NW, Women and Families Centre, Midwifery and Mental Health teams all offer services through the refuge.

One survivor described how her priority status and access to housing options changed once she was in refuge. She said very clearly that she hadn't wanted to go to refuge and yet because access to priority status and pathways between refuge and social housing options weren't available to victim-survivors in the community she had been forced to access a refuge when her abuse escalated.

"As soon as you went in to refuge you went up the housing list and you could talk to housing about what situation you were in, until I went to refuge nothing else mattered I was adequately housed. It took going there to go up the banding – from bottom level to top, because you're classed as homeless, and it just feels like the referral from Bridges should have been enough to get that support."

Survivor interview

Refuge services are both crisis services and long term services for women. Women can and need to make multiple use of refuge, leaving an abusive relationship is not a linear process and women take many attempts to leave and find safety. Knowing the refuges are available and that you can go back to them if you need to can provide a huge range of psychological safety for women even when they have returned to their perpetrator:

"I left my husband five times, I've been placed in the refuge five times. I started to leave in 1997 the first time was on police advice. There were loads of places you could go then. This last time back in November 2019 there were a few times the police had been called and we both had social workers involved, the social workers told us we needed to split up so we both went on the housing list. [at the time of the most recent crisis] I rang my social worker from the bathroom, and she asked a lady from the domestic violence team at the council to contact me. She told me I had to get out of the house, so I packed a bag and went straight to housing Ashton. I sat there all afternoon, when they tried to close I asked them "what happens now?" They said come back on Monday morning, so I stayed the weekend in a hotel with my daughter. When I went back they found me a place in the refuge by 4pm on the Monday."

Older survivor interview

Some survivors commented that they were in the refuge too long because of a lack of move on accommodation, this is a picture seen nationally – women report being in refuges longer than they wanted to because of a limited housing stock and a lack of ability to access private rented accommodation. Women suggested that attention to moving women out of refuge should be considered as much as moving women in given the impact it has on health and well-being:

"One of things I found when I went into refuge I was told I won't be in there very long, I was told different things – some people told me it won't be very long, some six weeks and then re-housed, and then you get to six weeks. It needs to be more realistic about how long you might be there before you get there. When it got to six weeks I had a massive dip because I thought I'd only be here a few weeks and I was still there. She should have known better. One thing I wish had been different is I wish I'd been told it wasn't a short thing. Because I was nominated I got out sooner and I got out in four months – that was quite quick I did well."

Female survivor interview

"Trying to get women out of the refuge and life line out of the refuge, I think it would help women, especially if they are on their own, it will help them get self esteem and out quicker. When partners didn't let them work, they weren't used to it, it seems too big, and it does make you feel better. I'm so proud of the fact that I still worked through that, I didn't take any time off, I didn't do any of that. I am always proud of that, it gives you those little confidence boosts that you need while you're building yourself up."

Female survivor interview

3.5.1.4 Refuge Spaces for Men

"There is just no support for men, and not enough even for women, you need to feel as though there is some help out there, I was just thinking on my own. Knowing someone is out there and can help, you ask for months and all you get is 'no' it feels as though everything is against you. I know you can ring up and talk to people on the phone but it doesn't help long term or help building your life back together. It's not just the separation. There needs to be a specialist service for men – it needs to feel separate for men."

Male survivor interview

Many of the people in Tameside we interviewed as part of this needs assessment were under the impression that there were no male refuge spaces. This is despite dedicated local refuge spaces for men and a growing national offer:

"The number of services offering refuge and outreach services to male victims in this period increased from 26 to 36 and 45 to 55 respectively. The increase in the number of services offering refuge to male victims may be due to better funding availability, combined with service providers recognising the need for male victims to access these services."[22]

Local knowledge of these support services seems lacking, the council's own website doesn't give details of the national domestic abuse helpline for men instead points to a little known men's aid helpline part of the European network for fathers.[23]

[22]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimservicesenglandandwales/november2020

[23] https://www.tameside.gov.uk/domesticabuse

It is worth noting that in some interviews attitudes staff held attitudes towards male victims that were hierarchical in its thinking, implying that the needs of male victim-survivors were more important than woman victim-survivors. Professionals were rightly worried about barriers to access to safety for men but this attitude was not linked to understanding of the local service offer. The AVA team were told that "men can't leave because they had 'nowhere to go". When asked direct questions about use of the national men's advice line there was limited professional understanding or curiosity about service offers.

Practice Recommendation:

- Local communications on the national and local gender specific service offer for male victim-survivors should be prepared and widely circulated to all frontline staff.
- Separate access points for male victims could be created that can be tailored to local messaging and need.

Alongside a limited understanding, some professionals displayed attitudes that were problematic in that by articulating the need for specialist services for men they demonstrated a belief about gender roles and stereotypes that might limit women's service offer. One professional in particular talked about how men couldn't access refuge because they didn't want to leave their house, they had to work and stay local: "men can't go to 'Timbuktu' in order to find safety." All of these viewpoints are just as applicable to women who also want to stay local and protect their employment and access to children.

3.5.1.5 National and Local Demand for Local Refuge Spaces

Refuges operate as a national network of services to offer safety to victim-survivors who are unable to stay in their locality due to the dangerousness or reach of the perpetrator of abuse. No local data was made available to the AVA team on the number of victim-survivors who enter Tameside refuges from outside of the area.

Data Recommendation:

- Refuge performance data monitor referrals into Tameside from out of area.
- Data should be collected on numbers of victim-survivors who decline a refuge space because they want to stay local (and their demographics to check for trends).
- There should be stronger performance management data on the numbers of refuge referrals declined and the demographics.

The number of refuge services for victims of domestic abuse across England has been decreasing in recent years. In the year ending March 2019 an estimated 67% of referrals to refuges were declined in England with approximately one fifth due to a lack of space or capacity.[24]

It is hard to assess demand for refuge because staff perception can act as a gatekeeper to local and national services. Perceptions of high demand might limit frontline staff's desire to use refuge as an accommodation solution, despite an understanding that "refuge is the best accommodation for domestic abuse support" [housing staff interview].

The narrative around high demand for refuge might shape individual attitudes and staff practice. Staff working in housing talked about refuge taking "too long to access" and complained about refuge referrals not being 'same day decisions' and told us that because of the shortage of refuge spaces, 8 out of 10 times survivors can not access a place that day. In reality the numbers of refuge spaces being declined in Tameside fall well below the national average. Across England in 2020 67% of refuge referrals are declined (adult and child)[25] Bridges referral data collects data on all referrals to its service but does not disaggregate referral data on account of service type. We cannot compare Tameside refuge declines to a national picture, because of this we can see how many adults and children are unable to be accommodated in Tameside who wanted a safe space at refuge.

[24]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimservicesenglandandwales/november2020

[25] Domestic abuse victim services, England and Wales - Office for National Statistics (ons.gov.uk)

Table 6: refuge referrals – not accommodated – unpublished data supplied by TMB for 2019 and 2020

2019	Adults	Children	2020	Adults	Children
Jan – Mar 19	10	7	Jan – Mar 20	6	2
Apr – Jun 19	5	10	Apr – Jun 20	6	3
July – Sept 19	14	20	July – Sept 20	6	3
Oct – Dec 19	15	21	Oct – Dec 20	4	6
			Jan – Mar 21	4	4
Total	**44**	**58**		**26**	**18**

In 2019 (12 month window) Tameside were unable to accommodate **44 adults and 58 children** connected to those adults.

In 2020, this number was **26 adults and 18 children** (Jan 2020 – Mar 2021, 15 months).

Data has been provided on the themes of these refuge referrals, despite the overwhelming desire of local residents to stay local there have been occasions where women have had to leave the area in order to find safety.

Table 7: reasons for refuge refusal – TMB unpublished data for 2019/20

A	Location too close to perpetrator	19
B	Could not manage client needs	9
C	No Bed Space/Suitable space	35
D	Not Domestic Abuse as presenting reason	5
E	No recourse to public funds	2

In most cases the refuge location was too close to the original home/perpetrator or was known to the perpetrator or family. On one occasion a family member of the perpetrator was also in the refuge. This presents additional issues.

Whilst clients are not excluded due to additional needs, there is a limit within the refuge provision that can be accepted at any one time to ensure balance for provision of all clients to ensure safety. The needs that must be managed include understanding of clients substance use, mental health, post traumatic stress, chaotic behaviour and if any previous violence has been displayed within the refuge environment which can be destabilising for the rest of the women and children at that time or at all depending on need, especially as this is already a changing environment and the refuge must cover insurance requirements.

Some of the clients were single females (10) more were families (25) but these were purely down to not having the space to accommodate, except for 2 which required ground floor rooms for mobility and these were not available.

In interviews with the AVA team local professionals identified the following local challenges for finding refuge for families:

- Larger families
- Women with No Recourse to Public Funds
- Units for women who wanted to stay in Tameside
- Women with financial commitments struggled to access refuge.

Data Recommendation:

- Data should be collected on the numbers of resident who moved out of area to access safe accommodation by the housing and homelessness teams and by Bridges.
- Bridges Referral data should break down referrals by service types to enable a statistical picture to be built about local declined refuge accommodation and compared with the English average.

Practice Recommendations:

- Information on capacity in refuge should be shared with housing teams to ensure that vacancies can be accessed by housing staff
- Information should be produced for housing teams on referral pathways and intake processes for local refuge offer
- An offer of individualised grants to support individual need at entry and exit such as funding for storage for treasured possessions.

3.5.2 Sanctuary

Where possible we are seeking to ensure that victim-survivors can stay in their own home. This might reduce the issues that survivors report with difficulty accessing appropriate housing support and help survivors to stay local. One survivor commented:

"If you're able to stay in your home you should be able to".

There are a number of new protection orders that might support this alongside sanctuary or target hardening schemes. The housing guidance accompanying the Act details how use of sanctuary schemes can improve victim's choices and should be teamed with a full understanding of safety and the dangerousness of the perpetrator and their patterns of behaviour. Guidance details where sanctuary is not appropriate including when the

perpetrator retains a legal right to enter the home or if the victim continues to be at risk in the vicinity around the home.

In Tameside Bridges coordinate the sanctuary scheme, they have shared data indicating that there were 113 referrals in the year 2020-21.

Sanctuary - A Case Example

> "We do as much target hardening as possible to make people feel safe in their own home. We walk through a person's property to identify areas where they need extra areas for security. New doors, locks on windows, flood lighting, fireproof proof letter boxes and locked letter boxes. We take each case on merit, because there's less money than there was for it. We base recommendations on the detail in the referral – if the perp accessed property through the window etc. we make sure we lock the window. We can talk about sanctuary measures during safety planning sessions. It can be mobilized quickly – for example if the perp has the keys then we can get locks changed that day. It does take longer if it's private housing but no one refuses extra security on a property."

Practice Recommendations:

- Increase access to the sanctuary scheme for professionals outside of Bridges.
- Increase resourcing available so that sanctuary measures can be deployed more quickly.
- Produce information for all frontline professionals on the local sanctuary offer, how it can give breathing space to victims. This information should make clear where the offer is appropriate and when it might not be.

Data Recommendation:

- Data should be integrated at a strategic level on a quarterly basis about the use of sanctuary schemes.
- Referral data should be collected from key housing and criminal justice partners on referrals for sanctuary measures.
- Collect data on the cost and cost benefit of sanctuary scheme measures.
- Data should be collected on where sanctuary measures have been declined by victim-survivors or landlords to assess the suitability of the intervention across demographics.

Chapter Four:
Understanding Health Needs

The guidance that accompanies The Domestic Abuse Act creates a new duty to refer between specific health departments and housing authorities for those threatened with homelessness.

The Act prohibits GPs and other health professionals from charging a victim-survivor for a letter to support an application for legal aid.

Orientation

Domestic abuse has a considerable impact on both adult and child victim-survivors health and well-being. The direct and immediate physical effects of domestic violence include injuries such as bruises, cuts, broken bones, lost teeth and hair, miscarriage, stillbirth and other complications of pregnancy.

Longer term academic research has also found that domestic abuse may cause or worsen chronic health problems of various kinds, including asthma, epilepsy, digestive problems, migraine, hypertension, and skin disorders. Domestic abuse also has an enormous effect on

mental health, and may lead to increased use of substances such as alcohol, prescription medication or illegal drugs.

Despite the documented high health needs of domestic abuse victim-survivors the only health data listed on the domestic abuse score card comes from the Tameside Trauma and Injury Intelligence Group who list that 26% of all assaults are related to domestic abuse (210 assaults) which seems an under-representation given national data sets.

Victim-survivors consistently told us how perpetrators had damaged their sense of self, their self-esteem and their self-confidence alongside the physical and sexual abuse they experienced and as a result in this needs assessment we pay particular attention to the mental health needs of victim-survivors.

4.1 General Practice

We received no data on the numbers of patients identified with historic or current domestic abuse through General Practice. Bridges data we were given showed just one referral to Bridges from a GP.

Data Recommendation:

- CCG should collect data on numbers of patients with historic or current domestic abuse in their file.
- Tameside strategic domestic abuse partnership board should develop key performance indicators for General Practice on domestic abuse to ensure compliance with the new Act and associated guidance.

"With the doctors because I couldn't go in for appointments anyway I didn't want to try and speak to them on the phone. Because I wasn't sure I didn't want to kick up a fuss. Because he [perpetrator] gaslighted me, and told me I'd heard it wrong I thought I might be overreacting or being too sensitive. It didn't feel right but because I'd been with him for ten years, how could I have got this so wrong."

Survivor interview

The AVA team asked professionals to give their perceptions of how domestic abuse survivors are identified and supported through General Practice:

"Clients tell me the GP doesn't have any time to ask any questions, they deal with one issue and then you're out. I can understand why people do not think it's a safe route, there is no training for GPs on domestic abuse."

Specialist service staff interview

A significant amount of GP time is spent helping patients with their mental health needs, one CCG commissioner estimated as much as 70% of their working day is spent managing mental health presentations. It is likely that there are many domestic abuse survivors and perpetrators seeking help for mental health issues that are currently being missed but we have no way to quantify the numbers.

Practice Recommendations:

- GP's, reception staff and those who work from GP practices should be given training on identification of current and historic domestic abuse.
- GP's practices should have up to date information on the local domestic abuse pathway and the new duty to refer to housing agencies.
- GPs managing mental illness should ask questions about domestic abuse experiences particularly in understanding escalating perpetrator behaviour.

4.2 Accident and Emergency

It was not possible to get figures from Tameside General Hospital on the number of injuries presenting at A&E where domestic abuse was suspected but not asked about or followed up on. We have not been able to talk to staff about the training available for frontline staff or how domestic abuse is recorded in patient records. Nor have we been able to ask about staff skill in balancing confidentiality, dignity and privacy with safeguarding and protection from harm.

In the SafeLives' report, "Getting it Right First Time", nearly a quarter (23%) of victims at high risk of harm and 1 in 10 victims at medium-risk went to Accident and Emergency (A&E) because of acute physical injuries. In the most extreme cases, victims reported that they attended A&E 15 times.

One survivor we spoke to described how she had attended A&E after an incidence of intense physical and sexual violence left her with internal injuries, she was passing blood in her urine and had sought help. She told the triage nurse that she had been kicked by a horse, no one questioned her any further even though she believed it was obvious that the injuries had been caused by her partner.

The Emergency Department (ED) at Tameside General Hospital had over 87,000 attendances during the period August 2017 – December 2018. The service is rated as 'good', but the 2019 CQC report notes that in ED, the trust did not meet their national performance targets for

patients admitted, transferred or discharged within four hours of arrival at the department, and the trust did not meet national performance targets that state that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. This might indicate a high demand on the service and, perhaps, a shortage of frontline staff.

4.2.1 A&E and Mental Health

SafeLives research on the health needs of victims shows a particular theme of need for those victim-survivors who do attend A&E:

"Hospital victims were also more likely to have been suicidal or to have self harmed, and many were referred to the IDVA after taking an overdose linked to the abuse they were facing. Just under half (49%) of hospital victims screened positive for post-traumatic stress disorder (PTSD), eight times as many as in an inner-city community sample (6%). One in six hospital victims (16%) had been to A&E for an overdose in the six months before seeing a hospital IDVA, compared to 1 in 38 (3%) before seeing a community IDVA."[26]

One survivor described being asked to attend A&E at points of mental health crisis, particularly around suicide intention, but said that the lack of care and understanding about domestic abuse actually made him feel worse:

"Hospitals aren't very helpful – you get told to go there if you feel really bad and you're just left in the waiting room at A&E but that's even worse. The hospitals just send you back home and then your GP looks at putting you on tablets. They treat you like they are too busy, if its not physical they aren't bothered about how you feel. It makes you feel like don't want to try any more – it's too hard."

Male survivor interview

[26] https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

Using SafeLives data set we suggest that across an average year there are approximately **20,000 attendances at A&E by victim-survivors each year** that are not receiving the identification and follow-on support they require. There is no way of quantifying how many victim-survivors this represents given the high number of victims that go to A&E repeatedly.

Practice Recommendation:

- Training and support should be provided for triage and reception staff at A&E on how to enquire about domestic abuse using IRIS interventions best practice guidance.
- Confidence that has been built on asking questions about South Asian women's experience on gender based violence should be used to increase confidence on asking all women who present with controlling partners or have particular injuries.
- With additional support – through a A&E based IDVA or dedicated case work time a pilot of routine enquiry should be trialled at Tameside ED.
- Information on the domestic abuse pathway should be provided to all A&E practitioners.
- Public awareness campaigns should target victim-survivors who attend A&E.

Data Recommendation:

- Data is required to understand how many patients at A&E are there because of current or historic domestic abuse – particular attention should be paid capturing the linkages between A&E crisis attendance for mental health presentations and existing known domestic abuse histories.
- Data should be collected on performance of any routine enquiry pilots.
- Data should be requested from CCG on training records of A&E staff on domestic abuse as part of their safeguarding offer.
- Data should be gathered that tracks victim-survivors attendance at A&E with other forms of state intervention such as police call outs – MARAC would be an established site for this.

4.3 Mental Health Needs

Table 8: PHE published statistics on mental health needs across England, Tameside and statistical neighbours data collated from mixed years

	Mental health							
	(2017) Estimated prevalence of common mental disorders(% population aged 16+)	(2017) Estimated prevalence of common mental disorders (% population aged 65+)	(2017-18) Depression : Recorded prevalence (aged 18+):	(2016/17) Depression and anxiety prevalence (GP patient Survey): % respondents aged 18+	(2017/18) Depression and anxiety among social care users: % of social care users	(2011) New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64	(2018) ESA claimants for mental and behavioural disorders: working age population	(2017/18) Hospital admissions for mental health conditions per 100,000
England	**16.9**	**10.2**	**9.9**	**13.7**	**54.5**	**24.2**	**27.3**	**84.7**
Tameside	**19.5**	**12.1**	**12.8**	**16.8**	**52.5**	**20.5**	**40.8**	**118.8**
Rotherham	**18.6**	**11.6**	**13.4**	**16.1**	**56.4**	**19**	**40.1**	**42.1**
Doncaster	**19.1**	**11.9**	**9.7**	**15.9**	**51.7**	**19.9**	**32.1**	**41**
St. Helens	**18.4**	**11.3**	**13.4**	**15.7**	**59.2**	**18.2**	**46.8**	**180.1**

Table 8 describes key mental health indicators in the general population of Tameside compared to the English average and the closest identified statistical neighbours. We draw your attention to the category of estimated prevalence of common mental health conditions 19.5% in the Tameside population in comparison to an English average of 16.9%.
In particular we note the links between poor mental health and higher economic need through a comparison between the ESA claimants for mental health conditions in Tameside in 2018 which were 40.8 per 1,000 vs 27.3 per thousand in the general England population. The severity of the mental ill-health of the Tameside population can be seen in the comparison between numbers of hospital admissions for mental health conditions, in the England wide data it stands at 84.7 per 100,000 population while in Tameside it is 118.8. This statistic in particular presents questions regarding early intervention for mental health support considering the high levels of hospitalisation.

Despite high levels of documented mental health need ,Tameside community mental health services do not collect data about domestic abuse, either from a victim-survivor presentation or a perpetrator presentation. The majority of mental health service provision is contracted to an external provider. This external provider has no requirement to provide data to the local authority on the domestic abuse needs of its clients, this creates a substantial gap in the knowledge base related to domestic abuse in Tameside.

Over 10,000 referrals to talking therapies are made in Tameside each year. Although over 65% of these are for women, there is no data on the appropriateness of these referrals for victim-survivors and whether perpetrators could be managed more effectively by understanding their mental health needs. The Respect consultation with perpetrators at the start of a pilot of Make a Change were told that the most common places for perpetrators to try and access information and support were friends and families and their GP while asking for mental health support.[27]

Data Recommendation:

- Data should be collected about current and historic domestic abuse for all IAPT referrals made in Tameside.
- Community Mental Health services should collect data on the identification of domestic abuse victim-survivors and perpetrators in their caseload.
- Data should be requested from commissioners on the training records of mental health staff on domestic abuse as part of their mandatory safeguarding offer.
- Engagement data on IAPT take up should be monitored for victim-survivors of domestic abuse to prevent wasted resources.
- Outcomes data on mental health offers should include outcomes on victim-survivors sense of physical and emotional safety.
- Data in the identification of perpetrators of domestic abuse should be captured and shared to inform the local business case on responding to perpetrators.

4.3.2 Mental Health and Suicide Links

Tameside has a demonstrated problem with suicide and suicide ideation. The understanding of the links between suicide, mental health crisis and domestic abuse are under-developed in some services in Tameside.

> *"If we feel that they (victim-survivor) are suicidal we contact mental health and the police but they tend to just sit on a waiting list.*
>
> ***Caseworker bridges interview***

Where explored, elevated rates of both suicide and suicidal ideation are found amongst victim-survivors of domestic abuse. Although the full scale is not known, one key study from

[27] https://www.respect.uk.net/pages/34-make-a-change

Refuge estimated that almost thirty women attempt suicide as a result of experiencing domestic abuse every day[28] and another study found that three women a week take their life as a result of abuse[29]. Although not in the UK, a US study that tracked women's use of a casualty ward discovered that domestic abuse was the single most important factor in female suicide. In this study, 65% of female suicide attempts were made within six months of visiting hospital for treatment to injuries inflicted by a partner or former partner. These statistics highlight a key link between suicide/suicidal ideation, and experiences of domestic abuse.

Looking at suicide in Tameside, there is no direct data that provides information regarding the rates of suicide amongst victim-survivors. Although we have no direct data, the chart below represents the most recent data regarding the average rates of suicide amongst the female population. This is represented below, alongside a comparison with closest statistical neighbours.

Table 9: (2016-18) Rate of female suicide per 100,00 published by UK Office for National Statistics

	(2016-18) Rate of female suicide per 100,000	(2016-18) Average rate of suicide per 100,00
England	**4.7**	**9.6**
Tameside	**5.9**	**11.6**
Rotherham	**6.4**	**13.1**
Doncaster	**5.2**	**12.3**
St. Helens	**4.1**	**16.1**

As the above illustrates, the suicide rate amongst the female population in Tameside is higher than two thirds of the statistical neighbours and the national average. This is statistically significant. Although the above may not evidence a direct causation, it provides sufficient grounds for the need to collect data regarding the potential link between suicide and domestic abuse in the local area.

[28] Refuge. (2017). Taking Lives. [online] Available at: https://www.refuge.org.uk/our-work/campaigns/more-refuge-campaigns/taking-lives/ [Accessed 22 Oct. 2019]

[29] Walby, Sylvia. (2004). The Cost of Domestic Violence. London: Women and Equality Unit

Data Recommendation:

- A data sharing protocol should be created between the coroner's office and key domestic abuse operational partners to check for domestic abuse histories or markers in the case of suicide or unexplained death.

Practice Recommendation:

- The Community Safety Partnership should consider commissioning Domestic Homicide Reviews in the cases of suicide and unexplained deaths with domestic abuse histories to inform learning on suicide prevention in cases of domestic abuse.
- Domestic Abuse should become part of the work of the suicide prevention strategy and action plan.
- Suicide prevention pathways and community outreach practices offer an excellent template for responding to attitudes and community stigma on early identification of domestic abuse.

4.3.3 Professionals Attitudes Towards Mental Health Services

"Mental Health services are a huge gap. I know services are really busy, I know how long waiting lists are for counselling and CBT but saying that mental health services don't need to know about domestic abuse is wrong. Women should be offered a proper mental health offer, a recommendation for support through a mental health charity like Mind to do online self-help work and mindfulness is inappropriate for survivors of domestic abuse. There is no understanding that in their head isn't a safe place, and asking people to spend more time in their thoughts, surrounded by the voice of the perpetrator, that's not ok. It makes it worse. If you're encouraging mindfulness listening to your own thoughts and body when you're in fight/flight – it's going to do more harm than good. People can't do it alone."

Interview with specialist services

"I get a lot of clients with a pre-existing mental health condition, sometimes a diagnosis of personality disorder or emotionally unstable personality disorder. It's often pre-abuse but it's

been made worse by the perpetrator. I wonder if they are targeted by them."

Bridges caseworker

"I have clients who can't get a PTSD diagnosis, they are reliant on their own research. GPs don't make referrals to psychiatric services when they should, they get told to try antidepressants first. There isn't the understanding that severe trauma isn't anxiety or depression. The GP isn't able to diagnose post traumatic stress disorder but does not refer to a psychiatric team who would or could. The trauma diagnosis is a huge relief for survivors but real struggle to get the right diagnosis".

Interview with specialist services team

"Abusive relationships damage the credibility of survivors, and her mental health needs make it worse, she just gets antidepressants or sleeping tablets which make her feel less in control, I knew one where the medication she was told to take affected her work, and her confidence and then it made her question whether she wanted to give evidence – she doesn't feel in control on high doses of antidepressants."

IDVA interview

"Mental health services are a black hole, if you're not well enough now for support then it's a closed door forever. They aren't flexible enough to understand multiple needs."

Interview with housing team

4.3.4 Barriers to Accessing Mental Health Services

The focus of mental health services on self-referral as a source of checking for engagement is a barrier for access for victim-survivors. It was particularly highlighted for the clients engaging with support from Diversity Matters North West. Women from South Asian communities discussed feeling "fobbed off" and like people are not taking their mental health needs seriously. A cultural attitude of 'doctors know best' and not wanting to put yourself forward are contributing to barriers to access for particularly marginalised groups.

In addition to barriers to access posed by self-referral, the staff at the Women and Families Centre highlighted how long waiting times for mental health assessments were a real barrier to access for their cohort.

A lack of flexibility in understanding the lived experiences of Multiple Disadvantage were also highlighted as problematic for victim-survivors. Professionals described a "three strikes and you're out" policy which had a particularly negative impact on women's engagement and trust in statutory mental health services. Staff at the Woman and Families centre noted

that the complexity of women's lives can be overlooked through this policy and when they are labelled as having 'poor attendance' there is no attempt to understand what might be happening in that woman's life, bad days and patches and the behaviour of the perpetrator.

Although commissioners were keen to highlight that they prioritised trauma informed approaches to mental health care, through enabling choice. In practice their approach fails to recognise the impact and/or nature of domestic abuse and falls short of a 'do no harm' approach expected in trauma informed services. In extreme cases women who were unable to attend appointments due to conflicting appointments due to child removal had no time to 'make the case' for why they were unable to attend mental health appointments and lost vital sources of support when they needed it most. In addition, women who get services withdrawn due to poor engagement have to go to "the back of the line" (waiting list) which is really difficult given that their poor mental health impacts on their ability to rebuild their lives and engage with other services.

Practice Recommendation:

- Flexibility in mental health provision is fundamental for survivors of domestic abuse considering both the difficulties that they are facing and potential sabotage by perpetrators where they are seeking support training that builds empathy and understanding of how victim-survivors mental health is impacted by domestic abuse would be a good investment for mental health staff.
- Understanding the way that victim-survivors are limited by perpetrators is an other good reason to ensure identification of survivors at the point of referral so that mental health services can be tailored to meet their needs.
- Professionals and survivors asked for mental health services to prioritise flexibility in their approach to domestic abuse and a person centred approach.

4.3.5 Mental Health and MARAC

There is no representation of mental health services at MARAC. The AVA team feel this is a missed opportunity given the high needs of survivors and the need to build a picture of the links between domestic abuse, mental health needs and suicide. CCG commissioners report that this is shortly to be addressed through a new contract with a dedicated resource for MARAC attendance.

Practice Recommendation:

- MARAC should build a local understanding of domestic abuse and suicide through data and information sharing from mental health at MARAC
- In commissioning mental health services should be required to think not only about their role in identification of victim-survivors, the management of perpetrator escalation but also the significant part they can play in supporting long term recovery

4. 4 Midwifery

Enhanced Maternity Services

Local Point of Excellence:
A key strength of the Tameside health service offer is the safeguarding support provided through the Enhanced Maternity Service. The flexible service accommodates the needs of families at a unique point in their lifecycle working with genuine motivation to change.

The Enhanced Maternity Service is a service offer for pregnant women with additional needs. A service which can flex to accommodate the needs of families who "don't fit in a box". It promotes continuity of care for women, a strong 'think family' approach and has a confidence in working with perpetrators in an early intervention and behavioural change model.

It holds low caseloads supporting 304 families a year in 20/21 - 15% of whom have needs around domestic abuse. This is slightly higher this year, with 17% of the 95 women supported listed as having domestic abuse support needs. Not all these women are identified as high risk, those that are would be referred to MARAC. The enhanced midwifery team have a strong multi-agency approach to risk management and safeguarding and talk fluently of working with other agencies where MARAC referral is not required.

Observations of Perpetrators

While there is no data kept in this service on the perpetrators, repeat/serial and high harm perpetrators the professional presenting, this service showed a good level of insight into perpetrator patterns in the area. For example, a member of their staff team talked about a demographic of younger perpetrators and shared a sophisticated understanding of Claire's Law used to encourage women to find out about serial perpetrators to make informed choices. The Safeguarding Lead in the service talked about the unique window of

opportunity for change making and the need for more training to encourage her midwives to do more work with perpetrators. The team also highlighted the need for a designated training offer to ensure that perpetrators were challenged by staff effectively and safely and that the opportunity to harness motivation was captured fully.

The complex and intersecting needs of this group of pregnant women were highlighted through this service, alongside gaps in perpetrator intervention and the major housing needs for their women and families. Safe and accessible accommodation was described as a huge issue for the maternity team. Enhanced midwives do advocate with housing but of particular concern were gaps in the provision for women with no recourse to public funds, and the need to stay in a local refuge to protect support networks and link with the midwife especially at the later stage of her pregnancy.

Although there was no data to support the detail from the interview, the Safeguarding Lead talked about the particular needs of women from Bangladeshi and Pakistani family backgrounds. The lead highlighted the need for heightened consideration of confidentiality, the use of specialist interpreters rather than family members and ensuring strong and established referral networks with Diversity Matters (local) Safety for Sisters (Manchester) and Southall Black Sisters (national). These are key considerations that should be adopted across all service offers.

Data Recommendation:

- Data from the enhanced midwifery team should be incorporated onto the domestic abuse scorecard.
- Data should be kept on whether families have been referred to MARAC or to the police to better understand how many of the families on their case load are 'unseen' in official figures to inform service design and local planning.
- Equalities data on the families served by the enhanced midwifery team should be monitored on an annual basis.
- Data should be kept on the perpetrator profile and resulting trends observed by the enhanced midwifery team.
- Data should be shared with the Housing Commissioners on the numbers and housing needs of women being supported by the team.

Practice Recommendation:

- Data should be kept on whether families have been referred to MARAC or to the police to better understand how many of the families on their caseload are 'unseen' in official figures to inform service design and local planning.
- Equalities data on the families served by the enhanced midwifery team should be monitored on an annual basis.
- Data should be kept on the perpetrator profile and resulting trends observed by the enhanced midwifery team.

Chapter Five:
Understanding Crime Data and Safety Needs

Orientation

The rates of domestic abuse that are reported to the police in Tameside are higher than all three of its closest statistical neighbours. Although police reporting numbers have stayed steady across the past three years[30] there will be a significant number of victim-survivors who are not counted by police figures, nationally Women's Aid data[31] suggests that only 28% of survivors using community-based services had reported to the police, although the percentage of refuge residents was higher it was still less than half (43.7%).

In Tameside the police record 4,424 public protection incidents relating to domestic abuse each year, 495 of which are classed as 'high risk', just 2.8% of all police incidents.

If we assume that Tameside is in line with national datasets then we can assume that the amount of domestic abuse in Tameside is, at a conservative estimate, more than double that recorded to the police.

Nationally there is a body of work which describes victim-survivors reluctance to approach the police for help. We asked local survivors to explain how they had found the police response. They told us about an inconsistent police response, with some who had a supportive approach from the local force while for others they were given wrong information and discouraged from making criminal cases:

[30]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020

[31] Women's Aid (2018) Survival and Beyond: The Domestic Abuse Report 2017. Bristol: Women's Aid

"[On seeking support from the police] there was a different response each time the police attended. There were times I felt I was in the wrong for seeking help from the police."
Survivor Survey response

"The police are very slow to come back with updates and take matters to court."
Survivor Survey response

Professionals were equally worried about the response from police towards victim-survivors and they mirrored the concerning attitudes raised by survivors:

- Police can be reluctant to build a criminal prosecution and victim-survivors are being encouraged to take out civil non-molestation orders.
- Some police officers appear to be making judgements about whether women will go through a criminal prosecution without discussion with the victim.
- Professionals at Bridges report being told that women "won't support a criminal prosecution" and when asked by the Bridges caseworker have disclosed that they weren't asked by the police to give a statement.
- Bridges staff hear that police are regularly telling survivors that "it's one word against another" and not collecting data that might evidence Coercive and Controlling Behaviours (CCB). Professionals found this frustrating: "it's a cop out to say we've got no evidence, most cases have no evidence, it's the police's job to prove it and evidence it."
- Professionals described incidents where domestic abuse survivors experiences were belittled by police especially in relation to requests about special measures, reports from specialist staff included women who were told "you're not a rape victim you won't get special measures" and "what do you want special measures for, you're not a child."
- The lack of communication between police and victim-survivor in relation to the perpetrator was noted as a particular area of concern, victim-survivors were regularly uninformed about arrests, remand or bail conditions. Many victims weren't told when perpetrators were being released, which has a real world implication for safety.
- Professionals reported incidences when bail conditions were dropped without making the victim aware, and evidence given of victims phoning the police to report a breach of bail conditions only to be informed that there weren't any bail conditions.

Data Recommendation:

- Performance data from local police forces (including gap between reporting, recording and arrest rates) should be regularly scrutinised by the domestic abuse partnership board.
- Data should be analysed for trends in relation to the use of civil measures and the demographics of victim-survivors being encouraged to apply for civil measures.
- Data should be collected on the communication and performance management of bail conditions.

Table 10: Domestic abuse related incidents reported to the police across England, Tameside and local statistical neighbours, mixed years published by the ONS.

	Crime, Safety and Violence		
	(2017/18) Domestic abuse related incidents and crimes per 1,000 (LAs are allocated the rate of the police force area in which they sit)	(2016/17) Reoffending levels - percentage of offenders who reoffend	(2018/19) Violent crime - violent offences per 1,000 population (LAs are allocated the rate of the police force area in which they sit)
England	25.1	29.2	28.2
Tameside	33.1	24.7	39.1
Rotherham	31.3	27.4	32.8
Doncaster	31.3	34	40.1
St. Helens	23.6	32.8	32.2

Table 10 demonstrates that violent crime rates are similarly higher than a number of close statistical neighbours and the national average, although there is no analysis of this as a domestic abuse crime type.

Importantly, we can see that Tameside has low rates of re-offending although practitioners were concerned about high repeats at MARAC and lack of analysis of perpetrator patterns which suggested a need for more disaggregated data on domestic abuse perpetration and an effective intervention upon incidents of abuse or violence.

Practice Recommendation:

- Domestic abuse strategic oversight group should collect data on survivor evaluation of the police response to domestic abuse in Tameside.
- Specialist services should provide 'critical friend' information to the senior police leads to encourage more victim focused provision.

5.2 The Multi-Agency Risk Assessment Conference (MARAC)

MARACs were pioneered by the domestic abuse charity SafeLives they have four key aims to safeguard victims of domestic abuse; manage perpetrators' behaviour; safeguard professionals and make links with all other safeguarding processes.

In the section below we offer observation of needs analysis based on the MARAC data available. It is worth saying at this juncture that one of the key aims of MARAC 'managing the perpetrators' behaviour' is not being met due to lack of records on perpetration being kept by the Tameside MARAC.

The Multi Agency Risk Assessment Conference is well established and well attended in Tameside. It helps promote referrals and joint working and information sharing to keep victims safe, in this way the AVA team believe that it meets three of the four key aims of a MARAC.

In line with national research, some professionals complained about a lack of time and analysis for victim-survivor cases at MARAC and given the 7% increase in case numbers this will be compounded. As one service manager pointed out, the MARAC in Tameside is large for a small Borough, having developed from once a month for a half day to twice a month for two full days due to a high increase in need. Capacity is the main reason professionals give for their service not being able to attend the MARAC. It might be that the case load has increased due to police referring directly to MARAC rather than the Bridges IDVA team.

The MARAC reviews approximately 450 cases per year, evenly distributed through the quarters. The majority of these cases are referred into MARAC by the police. This is higher

than across England where police make up just over 60% of referrals into MARAC. Specialist Services report a trend for police referrals being to MARAC rather than the case worker.

Table 11: Tameside MARAC referral sources – unpublished data provided to AVA by Tameside domestic abuse performance management, compared with National MARAC dataset on SafeLives website – data from 2019/20

	Tameside	**England**
Police Referrals	72%	63.8%
IDVAs	6.5%	12.2%
Children's Social Care	4.3%	3.3%
Adult Social Care	0%	0.8%
Secondary/Acute Trust	2.3%	2.5%
Education	0 %	0.2%
Housing	1%	2.8%
Mental Health	0.8%	1.2%
CCG/Primary Health	5.3%	2.5%
Probation	1.3%	1.6%
Voluntary Sector	3%	3.3%
MASH	0%	0.4%
Substance Abuse	0.3%	0.5%
Other	3.5%	4.8%

Table 11 demonstrates the high numbers of referrals coming from police to the MARAC, almost three quarters of all cases, significantly higher than England wide data.

We also draw attention to the fact that across England IDVA referrals to MARAC are nearly double what they are in Tameside. Possible analysis on this large gap comes from the observation, based on the data available to the AVA team, which suggests that the majority of people referred to the IDVA team are already known to the police. As such, the IDVA team is a source of actions and information to the MARAC rather than a route into the MARAC for victim-survivors otherwise unknown to services.

As might be expected from analysis provided in other chapters, rates of referrals into MARAC from acute health care settings is slightly lower than England wide data and CCG/Primary

health higher – predominantly due to the work of specialist services like the enhanced midwifery team.

Given high prevalence figures and well documented substance misuse issues of the Tameside population the AVA team expected to find a stronger link between substance misuse services and MARAC. We talked to the commissioned services for drug and alcohol harm reduction and they described strong expertise around the MARAC and referrals in. Despite this referral sources are just below the national average.

The lack of referrals between the local MARAC and the local MASH needs consideration given the new status of children.

Practice Recommendation:

- Further analysis is needed to understand the risk posed by perpetrators using substances and how the MARAC can best manage these risks and support victim-survivors.
- MARAC Practice needs to develop to consider how best to meet the needs of child victim-survivors.

5.2.2 Profile of Victim-survivors at MARAC

The MARAC data for Tameside gives an insight into the profile of 'known' victim-survivors in Tameside.

Table 12: Tameside MARAC referral data from 2019/20 (unpublished) compared with England data from the SafeLives national dataset (published online)

	Tameside	**England**[32]
% rise in MARAC cases	7% increase	9%
% of cases at MARAC who are B&ME identity	8%	16.1%
% where identity is LGBT	3%	1.3%
% where victim has a disability	3%	7.2%

[32] National comparators- from SL website Latest Marac National Dataset | Safelives

% where victim is male	4%	5.8%
Numbers of repeat cases	27%	32%

There is no analysis on the age profile of victim-survivors heard at MARAC and no analysis kept on perpetrators or their demographics.

The numbers of B&ME[33] victims being heard at MARAC is significantly lower than the national average and is also an under representation based on 15.8% of non-white residents in the census figures.

Although many British citizens are B&ME identities, there is a particular need for the safeguarding of and provision of services to those with insecure immigration status and recourse to public funds. All professionals spoken to as part of this need analysis identified significant issues facing women with no recourse to public funds, and mirrored the well documented gaps in available state support for this client group.

There was also a lack of analysis on who was counted as B&ME – multiple identities appear conflated with little analysis on who these groups are. Professionals appeared to have a poor understanding of how data on race and ethnicity should be collected, an example illustrated in discussion on the needs of Polish residents. Professionals talked about large numbers of Polish residents but were unsure about whether they would be listed in the 'BME' category or would be listed as 'white other'. One professional talked about emerging numbers of 'African women' but without analysis we can not tell whether these 'African women' fall into other protected characteristics or high need groups.

Data Recommendation:

- Data categories on race/ethnicity should be agreed across the borough and all agencies trained in their use.
- Data should be analysed from DMNW to understand the under-representation of South Asian women in the MARAC figures.
- Ethnicity, Faith and Race data should be collected on the children who are presented at MARAC.

[33] Stands for Black and Minoritised Ethnic identities – we choose this language to demonstrate the powerful process of minoritisation in moving people from the centre to the margins based on structural inequality and discrimination.

The higher than average number of LGBT cases at Tameside MARAC is statistically significant and may be down to several factors. The specialist LGBT IDVA provided by Independent Choices may help to increase identification and referral and provide confidence to this community that they will be believed and supported. In the recent workforce survey we also see a high awareness of DA in LGBT relationships and this awareness might translate into open-ness and safety in helping relationships between professionals and LGBT victims. Local professionals also suggested that it might partly be the result of positive outreach by Tameside Council to reach out and support male victims. Although data isn't available, regular attenders at MARAC suggested that the majority of LGBT cases were same sex male relationships. The lack of data on perpetrators and their demographics hides an understanding of how many men are being abused by other men within their relationships.

Data Recommendations:

- Data on gender and sex of perpetrator should be collected for all cases.
- Particularly important in LGB cases/same sex domestic abuse.

Data Recommendations:

- Trends should be analysed to check for increased presentations of victim-survivors with disabilities and mental health needs.
- Understanding the mental health needs of perpetrators is key to managing any escalation .
- Health data should be shared more routinely with the MARAC to analyse trends.

Another statistic made visible through comparison with national data is the low numbers of victim-survivors at Tameside MARAC with a disability. This is interesting given the national prevalence of survivors with disabilities and the high health needs of Tameside residents particularly around mental health needs.

Although staff felt that a lack of focus on perpetrators meant that the Tameside MARAC was working with high numbers of repeats at MARAC the data shows that, actually, repeat cases at MARAC are significantly lower than the English average. Just over a quarter of cases at MARAC are repeat cases.

Chapter Six
Adult Social Care Needs

Orientation

6.1	Adult Safeguarding, Suicide and Domestic Abuse	Page 85

Tameside has an aging population with increasingly complex needs. In the adult population we see the long-term impact of high substance use (including alcohol related dementia). We draw attention to the high rates of suicidality and the high rates of domestic abuse.

Older adults experiencing domestic abuse should be safeguarded through the statutory guidance issued under the Care Act published in 2014. This update includes domestic violence as a category of abuse. There are clear links between adult safeguarding, domestic abuse, CCB and Domestic Homicide. In a thematic report of Domestic Homicide Reviews in London Standing Together point to the over representation of older victims in the DHRs and note that:

"The lack of exploration and action taken with the [older] victims identified in this report reinforces previous research findings that domestic abuse is not often considered as an issue affecting older people. Where victims presented with injuries or signs of mental health needs, their conditions were presumed to be the result of health or social care needs."[34]

At present identification of domestic abuse within Tameside adult social care is consistently low.

In the Safeguarding return for the last year there were 135 Section 42 enquiries, three of these identified domestic abuse as an area of concern. It was not possible to identify whether these three cases had met the MARAC threshold.

Tameside acknowledges the lower than average conversion from safeguarding concerns into section 42 enquiries. The Borough has a 23% conversion rate against a North West England average of 45%. Across England the majority of investigations are of women (60%) and 63% of all section 42 enquiries are for adults over 65.

The way that safeguarding concerns are loaded into the ASC system misses capturing the category of domestic abuse, and staff felt that domestic abuse might be being discussed but

[34] Standing+Together+London+DHR+Review+Report.pdf (squarespace.com)

classed as 'breakdown in carer relationship', self neglect and financial abuse. Furthermore, Adult Social Care also have no way of classifying/recording historic abuse:

> *"Sometimes the work is taking place with survivors after the risks associated with the abuse have been reduced, for example people have left their partners however the historical trauma is still having an impact on the people we support's well-being. In these situations we do not have a function to record domestic abuse as a support need in our system."*
>
> ***Adult Social Care – Safeguarding Lead interview***

The AVA team met with Safeguarding Leads in the local Adult Safeguarding Team about the links between MARAC and adult safeguarding. There was a perception (mistaken) that it was the role of police to refer to MARAC rather than social workers.

Data Recommendation:

- Review data categories available in the adult social care database and information management system to identify appropriate markers for historic and current domestic abuse.
- Data on age of victim-survivors and perpetrators should be recorded at MARAC.

Interviews with staff identified the need for a stronger more integrated training offer that supports adult social workers to better recognise patterns of coercive and controlling behaviour as domestic abuse. Older survivors told us about the impact that having social workers who didn't understand domestic abuse had on them:

> *"Years ago social workers [in adult social care] were ok but this time they weren't – his social worker would contact me and ask me questions about him, he was contacting me so much and I had to update him, there was no communication between social work teams in the hospital or community."*
>
> ***Survivor interview***

Possibly speaking to this survivors point about communication, staff identified a real need to increase in the workforce's understanding of the computerised record keeping system. This would enable local decision makers to establish a more accurate picture of localised need and would bring real changes to the service that older survivors receive.

The Adult Social Care staff team also discussed the need for more staff to have a better understanding of the local domestic abuse offer in relation to older victims and how the new policy changes might impact on provision. This might improve the appearance of silo understandings in the adult social care team:

> *["Was your social worker helpful?] "Not really, they appear to be, but you can't talk to them, they never get back to you. I think the social workers only wear one hat. They do not know about housing or benefits, there's loads of work that they do but and that but they do not know about domestic abuse."*

The lack of understanding about the changing benefit offer was picked up by another survivor as an area of improvement for adult social care:

> *"As a disabled person, I have limited financial means, am reliant on disability benefits and have no means of ever getting rid of this debt and social workers can't do anything."*
> ***Survivor survey***

> *"There is more that social workers could do yes, but I do not know what their workload would be like. They go out and see people but they do not tell you what they can do. They saw us in our home and saw us together, once when my social worker came to see me my husband wouldn't let us have the privacy we needed."*
> ***Survivor interview***

Practice Recommendation:

- Referral pathways between MARAC and Adult Social Care should be reviewed with the aim of making the needs of older adult victim-survivors visible.
- Adult social care workers should have up to date information about pathways for domestic abuse including financial abuse and should be resourced to provide goal oriented work for clients with these needs.
- Additional training is required on identification of victim-survivors within adult social care and the dedicated support offer required.
- Professional development and training should be offered to staff in adult social care on the identification of perpetrators of domestic abuse.
- Training and guidelines should be offered to all adult social care staff on safe and effective working with couples where there is domestic abuse especially when one is a 'carer' to reduce the emotional burden on victim-survivors and how to manage perpetrators.

6.1 Adult Safeguarding, Suicide and Domestic Abuse

In particular, the concern about safeguarding, suicide and domestic abuse as detailed above was a present gap at Adult Social Care. We asked the Adult Safeguarding Lead to review the Northwest Ambulance Service referrals to Tameside Adult Social Care. On an average week the Tameside Adult Social Care team received 60 referrals, of which domestic abuse was identified as a feature in four of the cases. No analysis is available on how the risk of serious harm is categorised, use of MARAC, or any detail about demographics.

The AVA team noted the large numbers of safeguarding referrals that were being made as a result of suicide attempts. In March 2021 alone Adult Social Care received 260 referrals on suicide. No data was available about the source of the referrals, whether the resident had a domestic abuse marker – either victim/survivor or perpetrator.

Data Recommendation:

- Data from adult social care should be scrutinised as part of the local authorities suicide prevention action plan especially triangulating between domestic abuse and substance need histories.
- Suicide attempts and data from the ambulance service should be part of routine domestic abuse data capture and demographic information captured as part of an understanding of need and service design.
- This information should be presented regularly at MARAC either by Health or Adult Social Care MARAC leads.
- All referrals received for suicide to adult social care should be screened for multi-agency domestic abuse markers – MARAC would be a good existing site for high risk perpetrators but pathways and information sharing agreements need to be built along the risk spectrum.

Chapter Seven:
Understanding Substance Use Needs

Orientation

Tameside's adult population has high needs around substance use and corresponding needs around mental health. Responsibility for supporting residents with these needs crosses service types and responsibility is the remit of several agencies. In particular we focused on the commissioned drug and alcohol service, adult social care and health agencies. Due to the overlapping responsibilities, responding holistically to those using drugs and alcohol is a challenge for all local authorities given the established picture of drug and alcohol use and domestic abuse though we need to consider it as part of this work.

Table 13: Substance use prevalence across England, disaggregated by sex, for 2017/18 published by PHE, table includes admission rates for alcohol related conditions and prevalence of crack and heroin use (not sex disaggregated)

	Substance use			
	Male admission episodes for alcohol-related conditions per 10,000	Female admission episodes for alcohol-related conditions per 10,000	Average admission episodes for alcohol-related conditions per 10,000	(2016/17) Estimate prevalence of crack and heroin per 1,000
England	3051	1513	2224	8.9
Tameside	3790	1837	2741	10.6
Rotherham	3207	1766	2422	11.8
Doncaster	3622	1888	2685	14
St. Helens	4051	1947	2931	11.9

Table 13 demonstrates the needs of local residents in the areas of alcohol and drug use and shows the high rate of alcohol use for residents.

Like its statistical neighbours, Tameside sits above the national average in relation to hospital admissions for alcohol-related conditions, both amongst the male and female population.

When taken together with its statistical neighbours, the admission rates are somewhat average, and estimated prevalence of both heroin and crack use are lower than all three statistical neighbours.

Table 14: reproduces the 2016/17 PHE data on concurrent mental health service use and substance misuse service rates for England, Tameside and closest statistical neighbours.

	Dual diagnosis		
	(2016/17) Concurrent contact with mental health services and substance misuse services for drug misuse	(2016/17) Concurrent contact with mental health services and substance misuse services for alcohol misuse	(2017/18) Admission episodes for mental and behavioural disorders due to use of alcohol per 100,000
England	24.3	22.7	69.2
Tameside	33.9	29.9	102.7
Rotherham	13	9.9	64
Doncaster	23.5	21.1	76.7
St. Helens	22.9	21.1	135.4

This table represents numbers in the local area experiencing dual-diagnosis. Tameside sits above both its statistical neighbours, and the national average, in relation to individuals in contact with both mental health and substance misuse services. Tameside sits significantly above the national average in regards to admission episodes for mental behavioural disorders due to use of alcohol. This is illustrative of service access, however difficult to dissect considering this can be taken both as a positive and a negative, high rates of contact with services can be taken as illustrating a high take up and outreach, but also a potentially higher rate of dual-diagnosis. Without a numerical comparison regarding the rates of those actually experiencing dual-diagnosis in the area, it is hard to analyse what these statistics mean in practice. In addition we have no data on how these high rates of dual diagnosis

impact on the issue of domestic abuse.

The Tameside DA Scorecard offers insights into the local understanding of the linkages between domestic abuse and drug and alcohol use – listing percentages of people successfully completing programmes for alcohol and substance use separately as part of routine reporting on domestic abuse in the area. However there is no breakdown of whether these completion programmes are for perpetrators or victim-survivors, there is no disaggregation on sex, age or other protected characteristics. More than two thirds of all people in drug and alcohol treatment in England are male (69%) and there is a national trend for earlier use of substances requiring treatment.

The DA scorecard has a data gap on the numbers of children living with parents who might be accessing support for their substance misuse. Nationally 21% of people starting treatment programmes have children living with them who are largely invisible to services, across England 81% of the children of people starting treatment were receiving no "early help" offer.

It is also useful to note that the completion rates listed on the DA score cards are well below the England average of 47% completion[35] for treatment programmes for drug and alcohol use. These low numbers of completion might speak to high levels of overlapping needs, inappropriate programmes for domestic abuse victim-survivors and/or perpetrators.

Data Recommendation:

- Data on domestic abuse, mental health and substance misuse should be more strategically integrated.
- Data on completion rates for substance use programmes should be informed by whether they are for perpetrators or victim-survivors and tied to the Borough wide outcomes framework.
- Data should be routinely collected on the demographic data of those using substance misuse services and performance data disaggregated along demographic lines.
- Data should be collected on the needs of children connected with those using substances and percentages allocated an 'early help' offer through MARAC or MASH
- Local performance data on drug and alcohol programmes should be annually checked against English average data available through PHE websites.

[35]https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report

Engagement and Duplication

Local Point of Excellence:
Engagement and preventing duplication
Tameside voluntary sector services working in drug and alcohol use have particular approaches developed to build trust and engagement.

The cohort and the complexity of need in Tameside makes engagement a challenge which requires flexibility and perseverance. Many agencies talked about how many service users had lots of agencies involved and reported being overwhelmed and losing track of "which agency does what". To counteract this, two services had developed positive engagement strategies for working with women facing multiple disadvantage:

- CGL in particular talked about building time to develop trust with their adult service users given the levels of Multiple Disadvantage.
- Staff from the enhanced maternity provision also talked about the complex and overlapping needs of women with addictions, mental health needs and domestic abuse and how austerity and covid had exacerbated this. This group of women who are marginalised from services by their experience of Multiple Disadvantage had a well known fear about children's social care involvement with their families. The Enhanced Midwifery Team's approach to providing continuity of care throughout a pregnancy developed trust and promotes honesty.

CGL Case Study – Preventing Duplication and Protecting Engagement

"Change Grow Live My Recovery Tameside had been supporting a female in relation to substance misuse since June 2017. During an appointment she disclosed to her Recovery Coordinator that she had been assaulted by her partner and that the relationship had ended. The survivor talked with her worker about her understanding that the abuse was wrong and shared her confusion about why she had stayed in the relationship for as long as she had. The Recovery Coordinator explained how she could benefit from a referral to Bridges, and that part of that support would include increasing her awareness of the dynamics of domestic abuse.

The survivor agreed to a referral and completed a DASH risk checklist; this identified that the abuse was high risk and that a MARAC referral was required. The survivor agreed to the referral. Following the MARAC referral, the survivor was allocated an IDVA. The survivor had previously found it difficult to engage with other services. In order to increase the probability of engagement the Recovery Coordinator liaised with the IDVA and shared strategies that would increase the survivor's engagement. This included making the survivor

aware of the dates of appointments with the IDVA and sending text messages to remind her to attend. Moreover, the Recovery Coordinator arranged for a burner phone to be given to the survivor because her phone had been damaged.

In addition, the Recovery Coordinator liaised with the Police; she shared the survivor's contact details, asked for them to make contact and encouraged the survivor to attend at the Police station for support.

The survivor engaged with the IDVA and was subsequently referred to Housing First. She was awarded a one-bedroom flat and her housing worker secured a resettlement grant to help her furnish the property.

Throughout this time Change Grow Live My Recovery Tameside continued to support the survivor in relation to her substance use. She received opiate substitution treatment as well as harm reduction advice including a naloxone kit (naloxone is a medication which can reverse the effects of opiate overdose), regular medical reviews and access to online support.

The survivor expressed that she was feeling unmotivated and had been neglecting herself, she also reported concerns about money. Psychosocial interventions were completed to support her to take steps to address her daily living skills and to reduce the risk of her returning to the relationship due to co-dependence. A referral was also made to Sandwich Angels, a team of volunteers who provide sandwiches to people experiencing hardship; they provided the survivor with a food parcel.

It was identified that the survivor had a limited support network, and a referral was made to MOTIV8, a local service that supports people to improve health and wellbeing, self-confidence, self-esteem, finance and employability skills.

The Recovery Coordinator established a regular contact regime with the survivor and attempted to contact her on a weekly basis. If contact was not made a risk management process was followed including contacting other agencies that were also providing support to the survivor. ”

Chapter Eight:
Children and Young People

The Domestic Abuse Act recognises children as victims of domestic abuse if they "see, hear or otherwise experience the effects of abuse." The Act places a duty on local authorities to support all victims of domestic abuse in safe accommodation such as refuges.

Orientation

Almost a quarter of young adults in the UK have experienced domestic violence and abuse during their childhood, and almost 1 in 20 (4.5%) children and young people in the UK have experienced severe forms of domestic violence[36].

Children and mothers who experience domestic violence are likely to do so on a repeated basis.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) recorded a total of 201,656 child protection referrals as a result of domestic-abuse related incidents in the year ending March 2018.

Domestic violence is also a key indicator for child abuse and neglect – with children experiencing domestic violence being three to four times more likely to experience physical violence and neglect.

AVA estimate that there are 11,035 child and young victim-survivors in Tameside from the total population of residents under the age of 19 in Tameside is 55,175.

8.1 Serious Case Review Data

A key site of learning on the way that domestic abuse is responded to locally is typically found in the Serious Case Reviews published locally. The NSPCC recently published the themes relating to the majority of Serious Case Reviews in England and Wales, a quarter of these had domestic abuse as a factor.[37] None of the four Serious Case Reviews on the

[36] children_experiencing_domestic_violence_signpost_summary.pdf (researchinpractice.org.uk)
[37] Domestic abuse: learning from case reviews | NSPCC Learning

Tameside LSCB website relate to domestic abuse though in one a woman describes a violent argument she does not identify her relationship as being characteristic of domestic abuse.

8.2 Identification of Children and Young People

Data Recommendation:

- AVA encourage Tameside to create a new scorecard specifically for child and young victim-survivors.
- Tameside are encouraged to disaggregated data along age types and protected characteristics of children and young victim-survivors.
- New KPIs and outcomes should be co-produced across the borough that relate to Children and Younger Victim-Survivors alongside performance indicators and agreed data points.

AVA expects that child and younger survivors of domestic abuse are identified by their school or educational establishment, their physical health care professionals, children and young people's counselling and mental health services, and by their friends and family.

Children and Young People often come to the attention of services at the point of crisis or when their non-abusive parent reaches out for help.

We see domestic abuse as a significant area of concern for victim-survivors in family courts and CAFCAS processes. The new Act extends new protections to child and younger victim survivors but also recognises post separation abuse, during which children are often used by the perpetrator.

When children are not identified because of an intervention relating to their adult caregivers they often come to the attention of services because of high behaviour needs. A recent review of children and young people's criminality by the Victim's Commissioner found a significant overlap between criminality, experiences of exploitation and domestic abuse in the home.

It would be wrong to focus our attention only on those who 'act out' and whose behaviour becomes problematic for society we also need to have strategies for the identification of children and young people who are living in fear of a domestic abuse perpetrator who are overly compliant. to avoid punishment, these children and young people need professional curiosity and continuity of care to watch for changes in behaviour. We should be just as

concerned about the children and young people who are hard to see as those who are more visible to safeguarding structures.

8.3 Children's Social Care (CSC)

Understanding of domestic abuse is a key factor in safeguarding children from harm, domestic abuse has been included in statutory frameworks on safeguarding for many years. A key area for understanding how a local area is responding to child needs is understanding local CSC data.

Fear of children's social care, of child removals and of 'mother blaming' by children's social care was reported in many professional interviews. This was particularly noted in conversations around barriers to accessing support for domestic abuse. Specialist services noted that CSC often put requirements on women to engage with the IDVA team:

> *"I've got quite a few clients where they won't want to engage with us, and nothing they want to work on and they ask 'what does my social worker tell you I need to do? Let's do that and you can leave me alone' We're meant to be a voluntary service but we have CSC placing demands on us."*
>
> ***IDVA interview***

> *"I get a lot of frustration from my clients when CSC are involved 'I feel like all these restrictions are on me, I won't have a drink, I won't go out with my friends, I won't leave my kids adults who don't have a police check' and he's walking around with nothing."*
>
> ***Bridges casework interview***

We mention this here as these attitudes have a direct limitation on the support available to children, the change in the status of children as a result of the new Domestic Abuse Act. Adapting services and processes regarding children as victims in their own right gives a significant opportunity for public awareness and reassurance on the attitudes of CSC to victim-survivors of domestic abuse:

> *"Because we don't see them as a victim we fall into the trap that the abused parent should be protecting them. But if the child was considered a victim of domestic abuse, how would we expect one victim to be responsible for protecting another victim. Society should be protecting both of the victims."*
>
> ***Professional quoted in VC Sowing the seeds report***

Practice Recommendation:

- Consideration should be given to how to communicate with professionals and residents that the changes in legislation will result in a change in attitudes within children and families services.

8.3.1 Children's Social Care Data

Tameside Children's Social Care has worked hard to ensure accurate understanding of the needs of children experiencing domestic abuse across the last five years. This has been a particular focus given their experience with Ofsted reports. The record keeping and assessment on domestic abuse was identified to be an area for development in the inadequate Ofsted rating in 2012. Since then there has been renewed focus on meeting the needs of children experiencing domestic abuse.

We were fortunate that information had already started to be prepared within Tameside on domestic abuse and CSC. A recent briefing note from the Performance Intelligence and Scrutiny Services Manager was shared with the AVA team. Much of the data below was collated through that exercise.

Within the Tameside Children's Service's LCS system, there are two main areas where reportable information regarding Domestic Abuse is captured in a reportable format.

- Factors in a Child and Family Assessment
- Notifications received from Greater Manchester Police

In order to provide an understanding of how the data relates to children open to statutory intervention the sets of data outlined above have been mapped to currently open cases to give an overview of prevalence within Tameside.

Demographic data on the children open to Children's Social Care was unavailable locally.

National data on the ages of children who are referred to children's services is not available, but the ages of children who are subject to a child protection plan indicates that younger children are more likely to receive this safeguarding intervention.

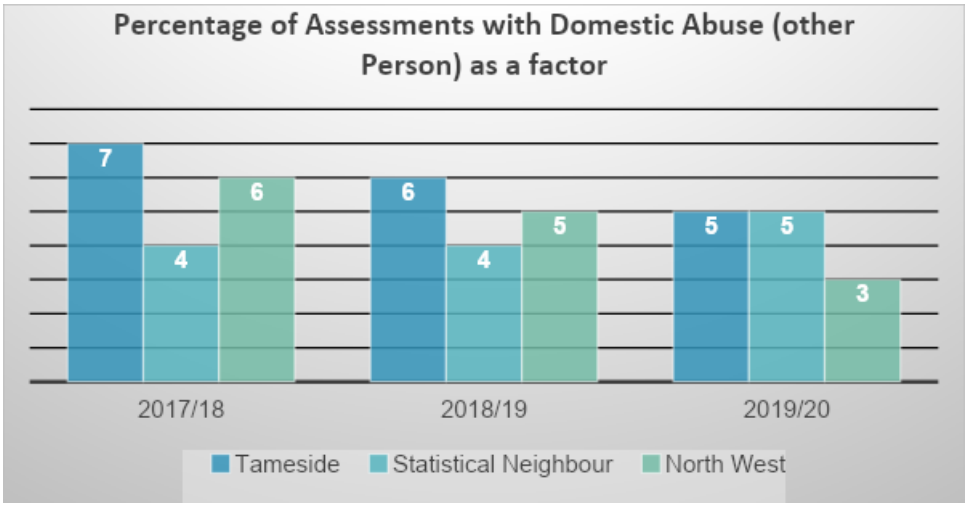
Across England Fifty children out of every 10,000 aged 1-4 were subject to a plan, compared with 44 of those aged 5-9 and 38 of those aged 10-15.

Local data identifies any Child in Need Episodes with assessment factors recorded in the year ending 31st March. Three factors relating to Domestic Abuse are recorded. Nationally published data does not cross-tabulate factor information and as a result comparator data on the total number of cases with Domestic Abuse Identified as a factor is not available.

- Domestic Abuse – Child
- Domestic Abuse – Parent
- Domestic Abuse – Other Person

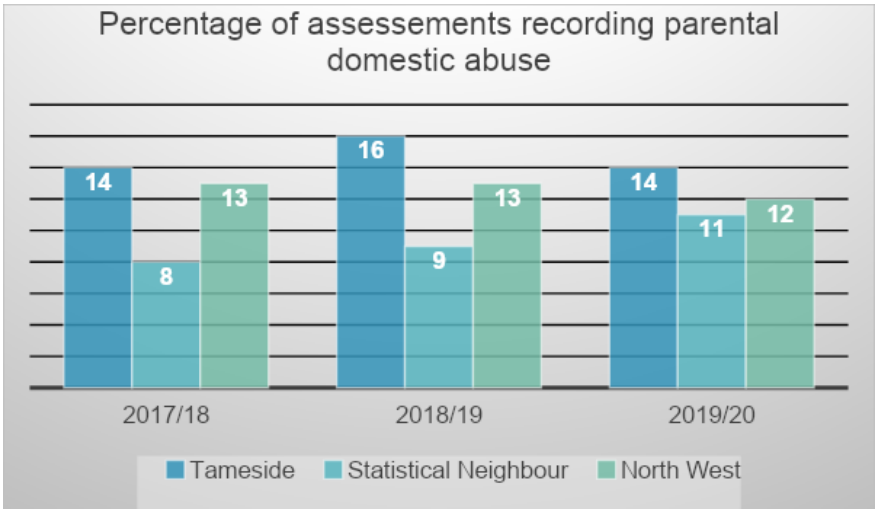
The section below looks at volumes of assessments completed where Domestic Abuse was identified as a factor.

Table 15: Tameside unpublished data on CSC Assessments with domestic abuse (other person) recorded as a factor



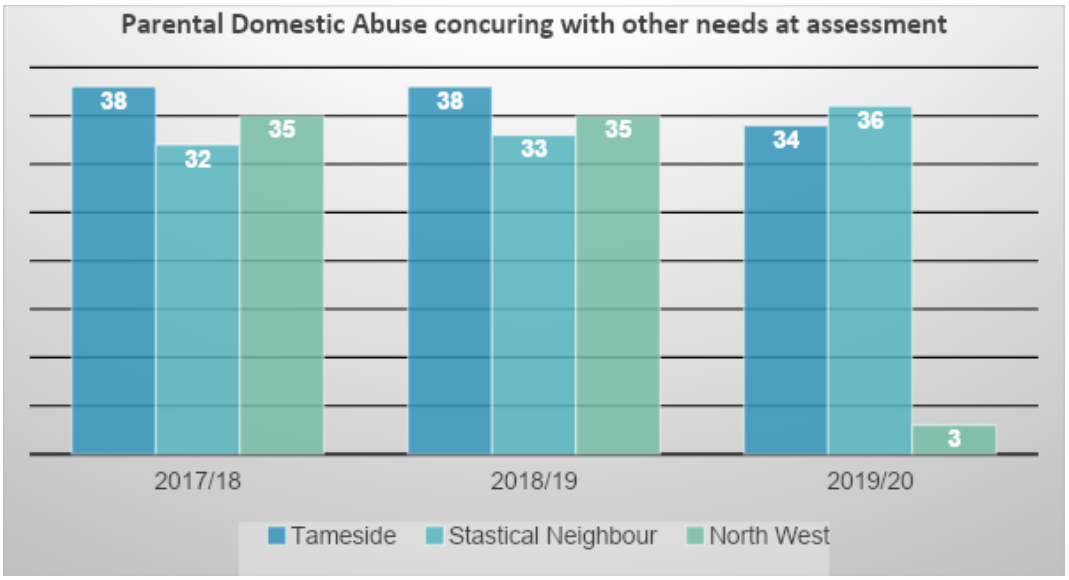
The percentage of assessments with factors related to Other Persons within the household have decreased in each of the last 3 years and in 2020/21 to date but remain broadly in line with comparators.

Table 16: Proportion of CSC assessments in Tameside recording parental domestic abuse (unpublished data)



The proportion of assessments in Tameside with domestic abuse involving the child is high when compared to both statistical neighbours and the North West average with a 3 and 2 percentage point gap respectively. Although the statistical neighbour average rate has grown in each of the last three years closing the gap between Tameside and statistical neighbours as a result.

Table 17: Parental domestic abuse concurring with other needs at CSC assessment (unpublished data)



As demonstrated in other places in this needs assessment the safety and well-being of children is directly linked to the needs of adult victim-survivors. We see this clearly when we consider the proportion of assessments in Tameside with domestic abuse as one of two or more factors at assessment as set out in Table 17.

From assessment to 'in need' classification; domestic abuse is the most common reason for children to be classed as 'in need' by local authorities and to be allocated a social worker – across England over half of all social work assessments identify Domestic Abuse as a concern.

In Tameside 30% of currently open cases in children's social care had domestic abuse as a factor. This data includes children who are currently Cared For by the local authority.

Children subject to Child Protection are significantly more likely to have domestic abuse identified with 54% of currently open Child Protection cases having one or more factors recorded. 32% of Cared for Children had Domestic Abuse factors recorded and 23% of other open cases rising to 27% when Care Leavers are excluded from this figure. This is in line with English averages.

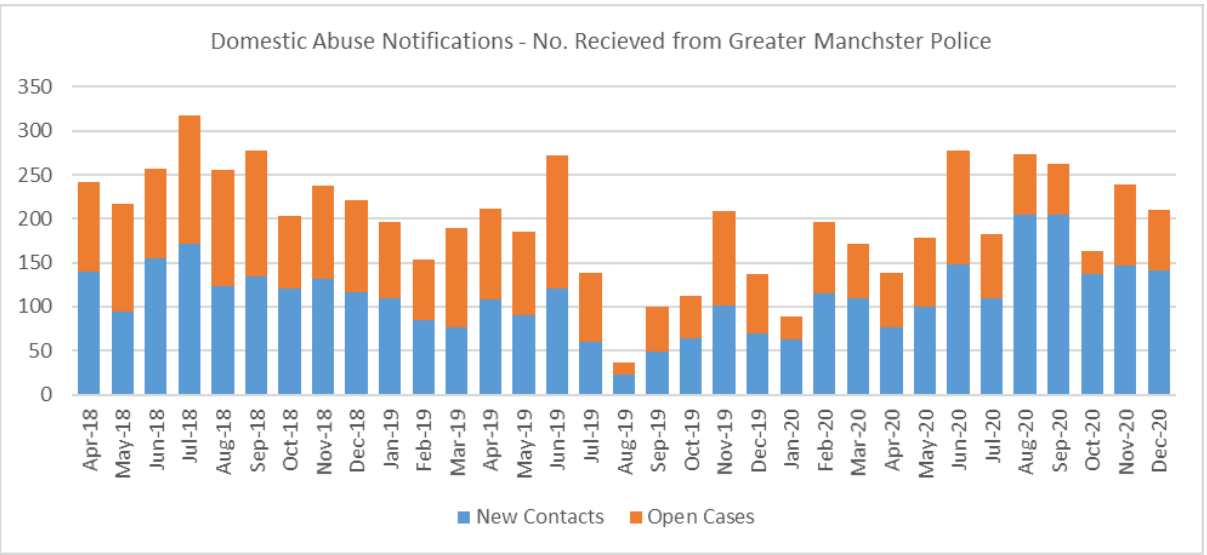
8.4 Domestic Abuse Notifications Received from Greater Manchester Police

Police notifications are the principal means by which children's services are informed about children's exposure to domestic violence and managing their high volume effectively is a challenge. A recent survey of Local Safeguarding Children Boards identified 30 multi agency initiatives designed to assess risk, although the involvement of agencies other than children's services and the police was uneven. Co-location, interagency meetings and integrated teams can all provide an effective means for agencies to share information as part of the process of filtering referrals and assessing risk.

Between 2018/19 and 2019/20 Domestic Abuse Notifications received from Greater Manchester Police reduced by just under 50% and have subsequently risen by 37% in the first 3 quarters compared to the first 3 quarters of 2019/20. This volatility means that trends in data are difficult to determine.

The chart below shows the number of notifications received since April 2018 broken down by the number received on open cases and on new contacts.

Table 18: domestic abuse notifications received from Greater Manchester Police demonstrating known cases vs new information (unpublished data)



8.4.1 Notification Risk Levels

The majority of Notifications received in 2020/21 are of medium risk with 71% at this level in the year to date. The overall proportion of high risk notifications received in the year to date has increased to 19% compared with 16% seen in the previous year.

The table below shows the overall number of notifications recorded each month broken down by recorded risk level.

Table 19: numbers of notifications and risk level for April – Dec 2020 (unpublished data)

Reporting Month	High Risk	Medium Risk	Standard Risk	Not Recorded	Total
Apr-20	18	105	13	3	**139**
May-20	26	124	23	6	**179**
Jun-20	54	204	16	4	**278**
Jul-20	38	131	10	3	**182**
Aug-20	63	194	7	9	**273**
Sep-20	33	194	24	11	**262**
Oct-20	24	121	14	4	**163**
Nov-20	56	154	16	13	**239**
Dec-20	46	139	9	16	**210**

8.5 Early Help and Families Services

Professionals were concerned that Early Help and Families services are not routinely recording details on domestic abuse.

In a focus group with Early Help, they highlighted a high number of families requiring support for domestic abuse, often those identified as 'low level' through EHAP or MASH screening.

They mentioned offering 1-2-1 domestic abuse sessions and the freedom programme for parents, and using the 'Love Rocks' package and support around healthy relationships with children. Staff highlighted how families were often referred due to children's behaviour at school or apparent mental health needs, but domestic abuse is often identified as the root cause upon assessment. Staff also noted the difficulty engaging perpetrators, and the need to do more work to avoid the onus of change and action falling on the victim.

> *"It is easier to engage the victim than the perpetrator. That's where we need the specialist support, working out how we monitor and plan for this as part of our support packages."*
>
> ***Early Help focus group participant***

We were unable to get concrete quantitative data from the early help service on victim identification, referral sources and demographics of families in the Early help offer. Children supported through the Women and Families Centre however shows that they provided direct support for 298 children and young people in the year 2019/20.

Data Recommendation:

- Early help data on identification of child victim-survivors, including referral sources and demographics to ensure commissioners are confident that child victims are getting the support they require to recover from their experiences.

8.6 Children and Young People's Counselling and Mental Health Pathway

Data was unavailable from the youth counselling offer although a staff member involved in this offer noted the high prevalence of domestic abuse amongst those accessing this offer, and that it is a large theme in the reason that young people are seeking counselling.

Data Recommendation:

- Data on identification of domestic abuse within children and young people's counselling and mental health service offers should be shared with domestic abuse oversight boards.
- Data on identification of domestic abuse with those seeking sexual health services should be collected as part of understanding children and young people's needs.

8.7 Family Nurse Partnership

Professionals involved in the family nurse partnership were proud of their strengths-based offer for children and families. This service ensures intensive support for families with children up to the age of 18. Despite an assumption that most women victims offered support through this partnership will have had extensive VAWG histories, no data is collected on present or historic domestic abuse and other violence against women crime type experiences entering this service.

Data Recommendation:

- Data on identification of child victim-survivors of domestic abuse within the family nurse partnership should be shared with domestic abuse oversight boards.

8.8 Bridges CHIDVA Service

Alongside children supported by a social worker the commissioned Bridges CHIDVA service works with approximately 150 children through 1:1 support.

The majority of children supported through the CHIDVA service are between 6 – 9 years old, there is no demographic details of these children or their other support needs.

In line with national best practice - children who are resident in refuge in Tameside are offered 1:1 support and group work sessions.

8.9 Children at MARAC

There are a high number of cases at MARAC with children involved, 56% of cases at MARAC have children involved, relating to 145 individual children. Of 'repeat' cases at MARAC 48% of victim-survivors have children.

It hasn't been possible to triangulate the data between the numbers of children at MARAC

Data Recommendations:

- Local data should be collected on the age and other demographic detail of children known to CSC, MARAC and MASH and supported through Bridges.
- Thought should be given by the domestic abuse partnership board on how to sensitively triangulate data between CSC, MARAC and Specialist Services.
- Data collected as part of SEND Assessments on family history should be shared with the domestic abuse partnership board to enable appropriate service design.

and the numbers connected with children's social care.

8.10 CAFCAS

National research by CAFCAS and Women's Aid suggests that as many as 62% of applications to the family court involve domestic abuse.[38] Their research details the impact of domestic abuse on children's mental health, ability to concentrate and maintain behaviour at school and directly impacts on the way they want to interact with the perpetrator. The AVA team were unable to access local data on family courts or CAFCAS reports.

Data Recommendation:

- CAFCAS and family court data should be collected and scrutinised routinely to create further insight into children experiencing domestic abuse in Tameside.
- Data on use of special measures in family courts should be collected and reviewed regularly by the domestic abuse strategic partnership.

Practice recommendation:

- Training and professional development for those connected with family court and child contact arrangement to ensure up to date knowledge of post separation abuse and use of family contact proceedings as such
- Performance data from family courts should be routinely monitored to check that perpetrators are not cross examining victims through the family courts

3

8.11 Youth Offending Service

The recent review by the Victims Commissioner suggests that a quarter of all children and young people in youth offending services have domestic abuse histories. In Tameside the Head of Service estimated it to be as high as 80%.

Data recommendation:

- Research on Young People connected to the YOT should check for domestic abuse histories
- Demographic details of young people supported by the YOT should be scrutinised to check for structural inequality and markers of discrimination

There is no consistent use of accredited healthy relationships programmes within the YOT offer, although staff were confident in describing how challenging negative attitudes to women was a focused piece of their prevention work.

The team described their pragmatic, coaching and solution focused approach to motivating change with this cohort:

"We have to be patient and keep going, putting in as much resource as you can."
Staff interview with the YOT

The youth offending team have recently done a lot of trauma informed training as part of a wider GM offer and understand the link between body regulation, communication skills and behaviour.

Practice Recommendation:

- Workforce development as part of a trauma informed understanding of child and young victim-survivors should focus on understanding 'acting out' and other conduct behaviour as communication about their abuse experiences.
- Particular focus on the training offer should focus on challenging discriminatory attitudes to young people, especially Black and Minoritised young people.

8.11.1 YOT and Housing Needs

Staff discussed the housing needs of this cohort and identified the challenges faced finding safe and suitable housing for young people coming out of custody as no services wanted to house them. Where this cohort was discussed in relation to leaving home/seeking housing and domestic abuse, staff highlighted that this cohort was unlikely to disclose domestic abuse. This makes them unlikely to be seen in the official housing figures.

8.12 Schools and Prevention

At the time they start school, at least one child in every class will have been living with domestic abuse since they were born.

Operation Encompass was noted by professionals as a good source of information and a strong offer locally. Operation Encompass relies on data sharing between Greater Manchester Police with Tameside schools. The Performance Intelligence and Scrutiny Service Manager was unable to bring together trends on the notifications from Greater Manchester police. Notifications appear inconsistent and can range from 210 per month to less than 40 per month. The majority of these notifications are at medium risk (71%) although it is not clear whether this risk notification is on the children or the adults in the house.

Data recommendation:

- Analysis should be made regularly on the quality and consistency of notifications between Greater Manchester Police and Schools in Tameside.
- Performance data should be collected on the support offer generated for children and young victim-survivors as a result of information sharing through Operation Encompass.

Alongside information sharing and support for victim-survivors at their educational establishments, schools are a significant site of information about domestic abuse that contribute to the understanding of healthy relationships.

Tameside commissioned the development of a new SRE curriculum and training programme in 2017. It is designed for Key Stages 1 – 4 and covers healthy relationships, consent, forced marriage, sexting. All 76 Primary Schools and 16 Secondary Schools in Tameside have access to the resources for free, they are regularly offered training in the content and building the skills/confidence to deliver.

Local Point of Excellence:
Free age appropriate, locally designed healthy relationships and domestic abuse prevention resources available to all schools.

Practice Recommendation:

- Services will need new guidelines and tools to consistently assess the needs and risk faced by child and young people victims-survivors.
- Local decisions will need to be made about whether children and young people victim-survivors should be monitored through MARAC infrastructure.
- Education providers need to consider how they share information with MARACs.

8.13 Young People and Drug Use

CGL have a specialist and dedicated young people's offer around drug and alcohol treatment, data analysis from that service hasn't been able to be included in this assessment due to capacity.

In an interview with the CGL Young Person team, he described the high numbers of referrals to the CGL youth service. There was an awareness that domestic abuse would be prevalent with that cohort but there is a possible recording gap.

Data Recommendation:

- CGL young people's service should be invited to contribute their data to shape the understanding of local young people's needs.
- This data should be disaggregated for sex, gender and protected characteristics to check for engagement of all those who require service.

Chapter Nine:
Domestic Abuse Perpetrators

The Act requires the government to introduce a national perpetrator strategy, which will include a new Domestic Abuse Protection Notice and Domestic Abuse Protection Order to help prevent reoffending and provide immediate protection for survivors.

Orientation

Nationally we have increased understanding that in order to create real safety for adult and child victim-survivors we must have an evaluated and consistent offer to not only manage and limit the harm of perpetrators but also provide an opportunity to create behaviour change with the aim of improving the lives of adult and child victim-survivors.

In Tameside professionals noted repeatedly the data gap in the analysis and understanding of domestic abuse perpetrators. Some professionals were consistently identifying them but felt unable to record details about them or offer them a service.

The lack of perpetrator offer creates opportunities for systemic victim blaming – holding one victim-survivor responsible for the protection of the other, rather than holding the perpetrator responsible.

"I read a lot of plans that say 'mum to attend the freedom programme or to attend a 'blank'. I don't see things saying a perpetrator needs to work on this…"

"There will be sweeping statements such as 'children are safeguarded' as mum ended the relationship. We have a lot of perpetrators who either move from one relationship to another. We think this person is now safe, but that person will go on to another family - and we are just waiting for that. That is seen as safe, but that perpetrator has gone to another relationship. The amount of times we have repeat MARACs or repeat perpetrators with different relationships with different children being impacted - that would be interesting to look at those stats."

Early Help focus group

"The impact on the children needs to be done with the perpetrators. Its about those perpetrators…doing words and pictures with children is powerful - but it'll be mum who sees them. It does educate the victim on what the impact on the children might be, but again - we are just focusing on the victim."

Specialist service interview

"We are really pushing to get absent parents included in family assessments. There is a big drive on understanding and speaking to those who aren't there. For us it's not just about the resident parents, we've redesigned the service to ensure we can do this – working on an 8am – 8pm service model not 9am-5pm schedule. This gives us an opportunity to work with parents who work 9 – 5 or only see their children at weekends. It enables us to share accountability for child welfare more evenly across the family."

Early Help focus group

Some professionals expressed concern about the impact of perpetrator programmes and the way that this might give false reassurance to victims-survivors. Professionals were keen to see a local service that was accredited and evaluated and for all work that was happening with perpetrators to be pulled into a comprehensive strategy with outcomes and performance indicators:

"We need a perpetrator programme we can measure. At the minute we do the odd bit of work - which is all really good - but it's not systematic. We can't count it, we can't say - this is how we work with perpetrators. We need something much more built in as an approach."

Family Services Manager

Practice Recommendation:

- Tameside's domestic abuse strategy should include a robust perpetrator strategy which includes a review of which services are working with perpetrators and existing good practice.
- The new domestic abuse strategy, outcomes framework and resulting action plan should include performance indicators and data management on perpetrator identification and survivor focused measurements of changing domestic abuse behaviours.

9.1 Existing Data Review

Although there is very little data available regarding perpetrators in Tameside and their patterns of behaviour some has been shared with the AVA team. We present this data and share where professionals have identified that they ask questions about perpetrators but at the moment have no consistent system for data capture.

Both the Enhanced Midwifery and the Early Help Focus group talked about a sense of perpetrators getting younger in Tameside we offer this case study to encourage commissioners to think not only of the need to manage high harm, entrenched perpetrating behaviour but point to the unique opportunity to make a lasting change with the resulting human impact and cost savings if we treat perpetrators with an effective behaviour change programme at the earliest opportunity.

"We had a case this week of a young girl who had been hit and punched by her boyfriend, both in primary school. Eleven years old. That's been picked up by us to do some immediate support around healthy relationships, but that brings it home I think."
Early Help focus group

Data Recommendation:

- Children Services should keep data on the profile of perpetrators and local systems should be created to share information on patterns of perpetration MARAC would serve for high risk perpetrators but further infrastructure would be required across the risk threshold.
- Data analysis of demographics of perpetrators can check for emerging trends and local profiles and resulting commissioning recommendations and service offers.

9.1.1 Bridges Data

Bridges report regularly on some perpetrator data including age and housing status. These are explored in the charts below.

Table 20: Bridges data from January 2020 – March 2021 on the nature of relationship between perpetrator and their adult victim-survivor (unpublished data).

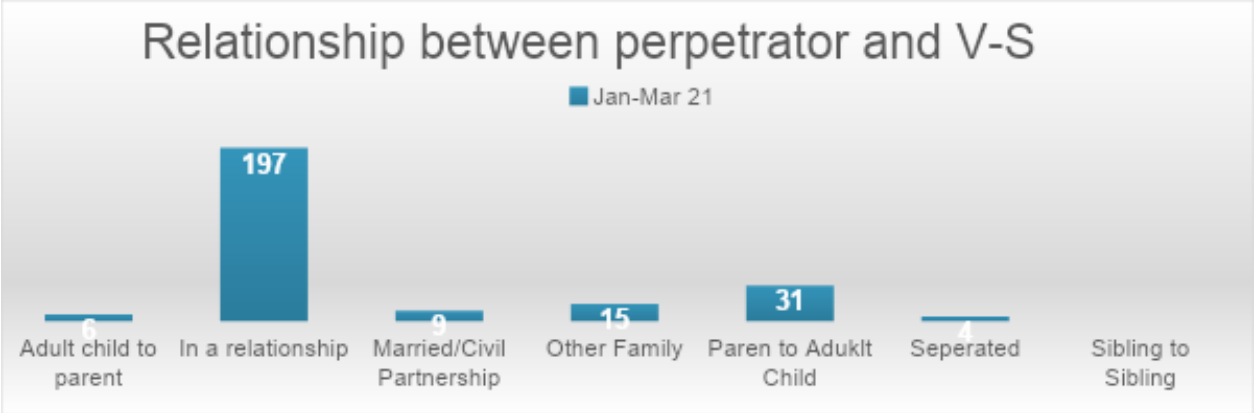
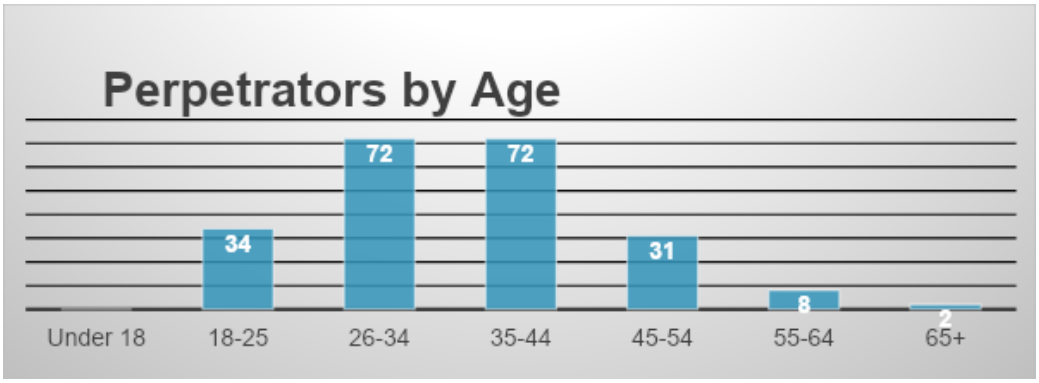


Table 20 illustrates that in the cases that Bridges work with the majority of perpetrators are in intimate relationships with their victims.

Table 21: gives an indicator of the age of perpetrators known to the Bridges service for the year Jan 2020 – March 2021 (unpublished data)

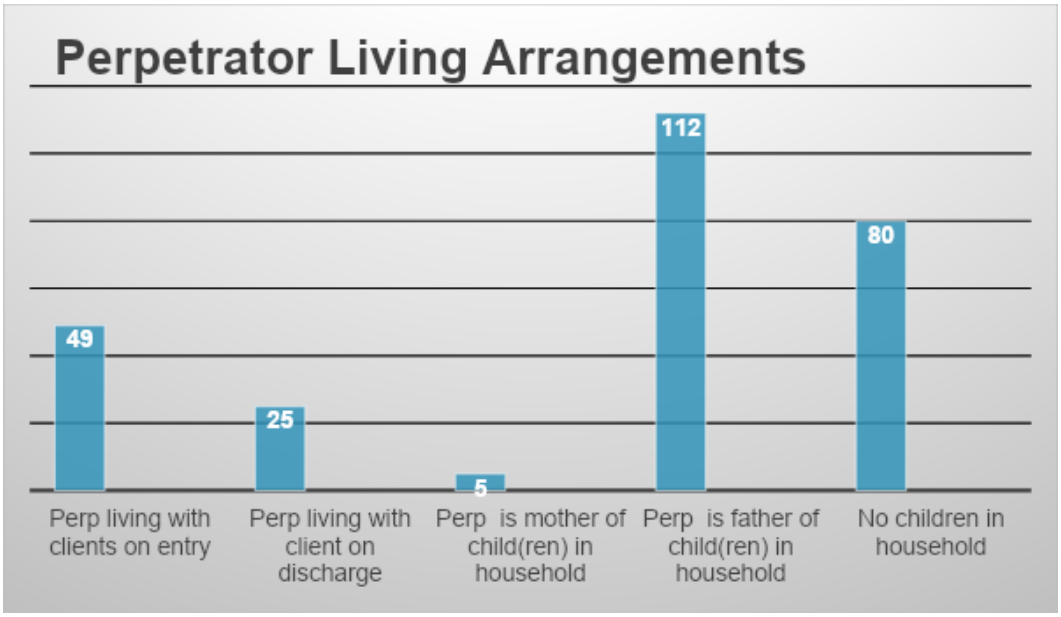


In the Bridges service the majority of perpetrators are between the ages of 26-44, with an even split between 34 – 44 and 26 -34.

Interestingly there are lower numbers in the 18 – 25 age group, this is interesting because the CSEW that showed that the majority of victims were in the age category 20 – 24 there is an expectation that the majority of perpetrators should also be in this category.

Bridges have identified no perpetrators under the age of 18.

Table 22: shows Bridges (unpublished data) analysis of the living arrangements of the perpetrators that they are aware of during the time period Jan 2020 – March 2021.



This chart illustrates that the majority of victim-survivors seeking support from Bridges are still living with their perpetrators, and more significantly demonstrates the high number of children living with an abusive parent. The data is inline with national data sets that demonstrate that the majority of perpetrators are the father of children in a household.

9.1.2 Housing Identified Perpetrators

In all interviews and focus groups with housing professionals in Tameside the AVA team asked about identification of perpetrators of domestic abuse. Housing professionals are required to ask a question about offending history and domestic abuse offenses during homelessness assessments. Answers to these questions are not shared routinely and no demographic data is kept on the perpetrators identified through homelessness assessments. If collected and shared appropriately, this would act as a key source of information regarding the perpetrator profile in Tameside.

Data Recommendation:

- Data on perpetrators collected through housing assessments should be shared with MARAC and other emerging perpetrator management infrastructures.

9.2 Identification of Primary Perpetrators

The Respect toolkit for working with male victims points to the importance of understanding the difference between primary perpetrators and victims.

"If male victims are incorrectly identified as the perpetrator or as part of a mutually violent couple, there are consequences which will put them and others at increased risk. Similarly, if men are incorrectly identified as the victim when they are in fact the perpetrator, this will mean that their partner/ex is identified incorrectly as the perpetrator or as part of a 'mutually violent couple'. In either case, incorrect identification is likely to have the following possible consequences:

Consequences for a victim incorrectly identified as a perpetrator:

- Not taken seriously as the victim by the Police thereafter
- Losing care of children
- Becoming even more isolated
- Feeling there is no alternative but to use violence and/or weapons to protect self and/or children, increasing risk to others.
- Increased use of alcohol, prescription drugs and other substances used as a coping strategy, which presents additional risks to self and to children, and also makes it harder for agencies to respond appropriately
- Psychological impact of not being believed – which may mean shutting down emotionally, minimising to self and others the nature and effects of the violence and thereby making it harder for agencies to respond
- Being referred to a perpetrator programme, which would be a waste of resources, inappropriate or unsafe and may increase depression or anger in the victim and increase control by the real perpetrator
- Increased risk of suicide, of abuse from perpetrator and of harm to children, as a result of the above.

Consequences for a perpetrator incorrectly identified as a victim:

- The perpetrator may be referred to victims' services, which is inappropriate, unsafe and a waste of resources

- The perpetrator/abuser may feel that they can do what they like to the victim without a fear of consequences and this in turn may result in an increase in severity and frequency of physical or other attacks
- The perpetrator will not have access to services which can help them change.

Consequences for the children:

- Child contact or residence decisions may be unsafe or inappropriate for meeting children's needs and welfare
- Children may be confused about what is happening and why
- They may mistrust authorities if they see the decisions as wrong or unsafe
- They may be put in situations of risk and danger."[39]

Interviews with professionals in Tameside across all services showed a lack of understanding about identification of primary perpetrator:

> *"You never really know if someone is a victim not a perpetrator. We have done work with both victim and the perpetrator in the service. We split the couple up between workers, but that is hard [both allocated a case worker within the service]."*
>
> ***Bridges Caseworker interview***

Professionals were particularly worried about this lack of assessment of primary perpetrator was damaging relationships with the LGBT communities and how it impacted on the assessment of male victims:

> *"When you've got two men it's really hard, sometimes police think it's assault and not domestic abuse or it's a 'fair fight' so when the police are called they just refer them both to a specialist LGBT IDVA service and they don't take any care about what's happening between them."*
>
> ***Bridges IDVA***

> *"If both parties are at MARAC at least one person will say 'they are both as bad as each other."*
>
> ***Bridges Caseworker***

[39] Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf (hubble-live-assets.s3.amazonaws.com)

Case Study – Not Identifying Primary Perpetrator

> “I worked with a female for a couple of months and then her partner was also referred in as a victim by the police, they showed no understanding about reactive violence. When we spoke to the police at the MARAC, the officer who attended hadn’t looked at the history or the previous reports. She’d been to MARAC 12 times in the past three years and yet the perpetrator had scratches on his face so they’d done a DASH with him, and referred him to MARAC.
>
> We felt like our hands were tied, we couldn’t ignore him but when we contacted him and went to meet with him we had to take another staff member with us because we were aware of his history and we wanted to make sure our worker was safe. He [the perpetrator] was quite dismissive, he had really negative attitudes to our staff and always assuming the manager was a man.
>
> His case was discussed at MARAC and the IDVA reported their conversations with him – it was difficult to say – but we did suggest he was the primary perpetrator and didn’t want to offer support. It didn't go down well at MARAC.
>
> The perpetrator then tries to use us, asking for supporting letters for court, access to legal aid, to make him a more effective perpetrator. He also used the fact that he’d been supported by us over the victim, she’d ask me about it, asking me whether it was true he’d also received support from our services. It was so frustrating because were a confidential service so we can’t confirm it to the victim.
>
> They can definitely use it as a way to further way to abuse their victims. In the end we managed to refer him on, we signposted to mental health services and through mental health he completed the APV program. There was nothing specific to refer him to.”

Alongside these case studies and interview quotes 61.7% of professionals in Tameside surveyed recently strongly agreed or agreed with the statement: “If both partners have been violent, they are both victims of domestic abuse”, it is likely that this case is not anomalous.

9.3 Perpetrators and MARAC

Despite the fact that a significant function of the MARAC is to manage information about perpetrators the Tameside MARAC does not fulfil this function.

The MARAC does not routinely consider perpetrators and, as such, has no ability to manage or observe patterns in serial perpetrators or perpetrator profiles. Not only is this a data gap it also means that it is rare that actions get allocated to perpetrators.

"We don't keep a track of perpetrators being heard at MARAC, when I present information on families following a domestic incident there are very rarely any actions taken down for the perpetrator. We're doing all this to safeguard the victim - the perpetrator is the elephant in the room."

Children's Services Manager Interview

9.4 Workforce Development

Although there was a lack of a structured approach to recording and working with perpetrators in Tameside, in interviews professionals talked about wanting to understand more about how to work with them and challenge them and ultimately help them to change their attitudes and resulting behaviour.

Professionals talked about wanting to know how to cut through minimisation, and challenge rather than collude with perpetrators. Some had received some training from Respect but talked about wanting to go further and to put it into a local context.

For many a training offer would need support from a service offer as part of a dedicated strategy.

Conclusions

AVA have enjoyed the chance to understand more about domestic abuse in Tameside, we can see clear recommendations in the area of future data collection and practice development that will improve systems and make the Borough safer for adult and child victim-survivors.

We believe that in order to bring these recommendations to life ongoing engagement with victim-survivors is key. We endorse the idea of the creation of a survivor board locally and encourage them to support the work in creating a strategy, an accompanying action plan and Borough wide outcomes framework and performance indicators.

There are areas of good practice across Tameside, we encourage you to build from these and join up local service areas to encourage better identification of survivors and their needs. We know that both survivors and perpetrators move between local authority service offers ensuring that they are provided with appropriate services and recording them and their outcomes will be the most essential data for the next round of local needs assessment in relation to domestic abuse.

Appendix 1 - National Prevalence Data

Victim-survivors

According to CSEW data for the year ending March 2020, an estimated 5.5% of adults aged 16 to 74 years (2.3 million) experienced domestic abuse in the last year. (ONS, 2020).[40] The police recorded a total of 1,288,018 domestic abuse related incidents and crimes in England and Wales (excluding Greater Manchester Police)[1] in the year ending March 2020. Of these, 758,941 were recorded as domestic abuse-related crimes, an increase of 9% from the previous year (ONS, 20200).[41]

Domestic abuse is a deeply gendered crime. Data from the Office for National Statistics finds that almost one in three women in the UK aged 16-59 has experienced domestic abuse in her lifetime (ONS, 2019[42]). It is therefore estimated that 26% of women (estimated 4.3m) and 15% of men (estimated 2.4m) aged 16-59 had experienced some form of abuse in the UK over their lifetime (ONS, 2018).[43] Research finds that women not only experience higher rates of domestic abuse, but higher rates of repeat domestic abuse victimisation and serious risk of harm or murder than male victims of domestic abuse (Walby & Allen, 2004[44]; Walby & Towers, 2017).[45] Over 80% (83%) of high frequency victims (more than 10 crimes) are women (Walby & Towers, 2018[46]) and between the year ending March 2016 to the year ending March 2018, 74% (270) of victims of domestic homicide (homicide by an ex/partner or family member) were female (ONS, 2019).[47] Perpetrators of domestic abuse on the other

[40] Office for National Statistics, 2020. *Domestic abuse prevalence and trends. England and Wales: year ending March 2020*. London:ONS.

[41] Office for National Statistics, 2020. *Domestic abuse prevalence and trends. England and Wales: year ending March 2020*. London:ONS.

[42] Office for National Statistics, 2019. *Domestic abuse prevalence and trends, England and Wales: year ending March 2019.* London: ONS.

[43] Office for National Statistics (ONS) (2018), *Domestic abuse in England and Wales: year ending March 2018*. London: ONS.

[44] Walby, S. and Allen, J. (2004) *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey. Home Office Research Study 276*. London: Home Office.

[45] Walby, S. and Towers, J. (2017) 'Measuring violence to end violence: mainstreaming gender', *Journal of Gender-Based Violence*, 1:1, p.11-31.

[46] Walby, S. and Towers, J. (2018) 'Untangling the concept of coercive control: Theorizing domestic violent crime', Criminology & Criminal Justice, 18: 1, p. 7-28.

[47] Office for National Statistics, 2019. *Domestic abuse prevalence and trends, England and Wales: year ending March 2019.* London: ONS.

hand are overwhelmingly male (Scott and McManus, 2016).[48] The number of women killed every year by men has been consistent at between 124 and 168 women killed each year - coming to just over two women a week (Femicide Census, 2020).[49]

We see the way domestic abuse and gender identity interplay through analysis of data on the lived experience of Trans* people. Trans women and men face significantly elevated rates of domestic abuse. 19% of trans people have experienced domestic abuse in 2018, this includes 21% of trans men and 16% of trans women (Stonewall, 2018).[50]

Young women aged 16-24 years continue to be the group most at risk of domestic abuse. In March 2015, the Crime Survey for England and Wales identified that 6.6% of men and 12.6% of women aged 16 to 19 had experienced domestic abuse in the past year (ONS, 2015).[51] However, SafeLives Children's Insights data found that nearly all (95%) of young people experiencing intimate partner violence were female (SafeLives, 2017).[52] A study from Refuge (2017[53]) also found that one in two young women have experienced controlling behaviour in an intimate relationship.

Where available, disaggregated data finds that Black and minoritised women are significantly more likely to face domestic abuse. ONS data shows that, in the year 2018-2019, Black and Minoritised women faced higher rates of both domestic abuse and domestic homicide (KSS CRC, 2020).[54] In London in 2005-2006, 59% of all homicides were of BME women (Thiara & Gill, 2009:43 as cited in KSS CRC, 2020).[55] The structural inequality[56] experienced by Black and Minoritised women due to both their race and gender transforms their experience of violence, meaning they often suffer more frequent and longer term abuse, and face additional barriers accessing support than their white counterparts (KSS

[48] Scott, S & McManus, S (2016) Hidden hurt: violence, abuse and disadvantage in the lives of women, Available at: https:// weareagenda.org/

[49] Femicide Census, 2020. 10 year femicide census, 2009-2018. London: Femicide Census

[50] Stonewall (2018). *LGBT in Britain: Home and Communities*. London: Stonewall

[51] ONS. (2015). Crime Survey for England and Wales. Office for National Statistics: London

[52] SafeLives. (2017). *Safe Young Lives: Young People and domestic abuse.* SafeLives

[53] Refuge and Avon's *'Define the Line' study (2017)*

[54] Kent, Surrey & Sussex Community Rehabilitation Company, (KSS CRC). (2020). Domestic Abuse in Black, Asian and Minority Ethnic Groups. [Online]. Available at: https://www.ksscrc.co.uk/2020/10/29/domestic-abuse-in-black-asian-and-minority-ethnic-groups/ (Accessed on: 5th March 2021)

[55] Ibid

[56] The embedding of inequalities across social structures in society, based on conceptions of differences.

CRC, 2020; Siddiqui, 2018).[57] It is discrimination and barriers to access to safety that explains the higher rates of VAWG against Black and Minoritsed women and girls (Siddiqui, 2018).[58]

Disabled women are also more likely to face domestic abuse. Disabled women are 2-5 times more likely than men and non-disabled women to experience sexual violence (Balderson, 2013[59]); that is 1.6 times for people with intellectual impairments and 3.8 times more likely for mental health service users (Hughes et al., 2012).[60]

Any grounded analysis of domestic abuse therefore demands an intersectional approach which accounts for overlapping systems of oppression which disadvantage particular individuals as a result of the spaces they occupy in hierarchies of power.

Perpetrators

There has been a growing awareness of the importance of targeting interventions towards perpetrators of domestic abuse. Most research takes an ecological model of understanding domestic abuse, anchoring understanding in a strong social context in which the gendered societal roles attributed to men and women and the cultural expectations of them are unequal. The majority of perpetrators of domestic violence and abuse are men[61].

We know that a quarter of high-harm perpetrators are repeat offenders and some have at least six different victims. These costs are disproportionately borne by women.

There are approximately 400,000 perpetrators causing high (including murder) and medium levels of harm across England and Wales[62] , and yet only a tiny percentage of these – fewer than 1% – gets a specialist intervention that might prevent future abusive behaviour.

Perpetrators whose victims are assessed at lower levels of risk are even less likely to get a specialist intervention.

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[57] Siddiqui, H. (2018). 'Counting the Cost: BME women and gender-based violence in the UK.' IPPR Progressive Review. Vol. 24 (4). pp. 361-368

[58] Ibid

[59] Balderston, S. (2013) *Victimised again? Intersectionality and Injustice in disabled women's lives after hate crime and rape.* In Texler Segal, M., Demos, V. (Eds.) Advances in Gender Research Volume 18a – Gendered Violence. Cambridge MA: Emerald Publishing

[60] Hughes, K., Bellis, M.A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., Officer, A. (2012) Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet*, 379 (9826): 1621–1629

[61] https://cwasu.org/project/project-mirabal/

[62] http://driveproject.org.uk/wp-content/uploads/2021/02/Call-to-action.pdf

Appendix 2: Statutory Duty Explained

Councils will now be required to give priority need to all victims of domestic abuse who are homeless and eligible for assistance, removing the subjective and harmful 'vulnerability' criterion that some housing officers currently use a gatekeeping tool or to turn them away.

The Act also maintains secure housing for domestic abuse survivors who flee their homes. Survivors with secure tenancies who have to flee their homes will now be granted a new secure tenancy when rehoused by councils, rather than the short-term leases commonly granted to new claimants.

Part 4 of the Act brings in a legal duty on tier one authorities to provide support to victims of domestic abuse and their children in refuges and other safe accommodation. Tier two authorities are required to cooperate with the lead local authority, as far as is reasonably practicable. The new duty will cover the provision of support to victims and their children residing in: * refuge accommodation; * specialist safe accommodation; * dispersed accommodation; * sanctuary schemes; and * move-on or second stage accommodation. Domestic abuse support will include:

- Advocacy support – development of personal safety plans, liaison with other services (for example, GPs and social workers, welfare benefit providers);
- Domestic abuse-prevention advice – support to assist victims to recognise the signs of abusive relationships, to help them remain safe (including online) and to prevent re-victimisation;
- Specialist support for victims with protected characteristics and / or complex needs, for example, interpreters, faith services, mental health advice and support, drug and alcohol advice and support, and immigration advice;
- Children's support – including play therapy and child advocacy;
- Housing-related support – providing housing-related advice and support, for example, securing a permanent home and advice on how to live safely and independently; and
- Counselling and therapy for both adults and children.

Appendix 3 - Full Data from Survivor Survey

Respondents = 52 (although on average 40+- respondents to each question)		
Themes	Findings	Analysis
Age	• Under 18: 6.7% (n=3) • 18-24: 4.4% (n=2) • 25-34: 26.7% (n=12) • 35-44: 22.2% (n=10) • 45-54= 24.4% (n=11) • 55-64: 15.6% (n=7) • 65+ (n=0)	No survivors over 65+. Majority of survivors aged between 25-44.
Gender	• Female: 84% (n=37) • Male: 13.6% (n=6) • Non-binary: 2.3% (n=1)	Majority female.
Sexuality	• 86.7% (n=39) Heterosexual • 1 'Gay/Lesbian • 5 Bisexual	Majority heterosexual.
Marital status	• 51% (n=22) married/civil partnered or cohabiting • 37.2% (n=16) single	
Disability	• 28% (n=12) identified as living with a disability *Of which* The vast majority identified as having a disability related to their mental health 70.6% (n=12), 29.4% (n=5) with a physical disability	There is an over representation of those living with disability (national average 16% [UK gov't]). We know that survivors are more likely to be living with disability than non-survivors. There are high rates of mental health needs identified in the cohort. Over 23% of all respondents reported mental health disabilities.

Race/ethnicity	• 86.4% (n=38) white • 13.6% 'Black and Minoritised': 2 Asian/Asian British respondents, 1 Black British 3 'Mixed ethnicity'.	Vast majority of respondents white, although an overrepresentation of Black and minoritised survivors in comparison to other cohort analysis in Tameside (e.g. MARAC)
Children	• 37.8% (n=17) no children • *Otherwise evenly split between 1, 2, 3+ children*	More survivors than not had children. This suggests a need to look at families, and support survivors around their needs as parents, and support children around the impact of domestic abuse.

Nature of abuse		
Themes	Findings	Analysis
Type	<u>In order of prevalence:</u> • **Emotional abuse**: 89.7% (n=26) • **Jealous and controlling behaviour:** 72.4% (n=21) • **Physical abuse:** 72.4% (n=21) • **Sexual abuse:** 37.9% (n=11) • **Financial/economic:** 37.9% (n=11) • **Surveillance/Stalking:** 24.1% (n=7) • **Harassment or unwanted attention in public spaces:** 24.1% (n=7) *1 respondent mentioned forced marriage, and 1 honour based violence*	Emotional abuse was the most common form of abuse faced, followed by physical abuse and jealous and controlling behaviour. There were also high reported rates of financial/economic abuse (over ¼) and sexual abuse (over ¼).

Perpetrator	• 72.4% (n=21) a partner/spouse • 31.3% (n=9) a family member *Other: foster carer, ex work colleague*	Survivors were more likely to have faced abuse from a partner or spouse than a family member.
How did you identify the abuse?	<u>In order of prevalence:</u> • **Conversation with a friend:** 48.3% (n=14) • **Police of criminal justice intervention:** 44.8% (n=13) • **Conversation with a health or education professional:** 34.5% (n=10) • **Research on the internet**: 20.7% (n=6) • **Article story or news on social media platform:** 17.2% (n=5) *A number of survivors chose to elaborate around how they identified the abuse they faced: the majority expressed that they 'always knew' that the behaviour was abusive, or came to the realisation over time.*	No survivors had identified their experience as abusive through either national or local awareness campaigns. There were high rates of police or criminal justice intervention (in comparison to what we know about survivors and policing i.e. much lower rates). At the same time, there were extremely low rates of identification through health services (despite statistics suggesting this is the first point of access for most survivors).

Accessing support		
Themes	Findings	Analysis
Received support in the last year?	Yes: 39.4% (n=13) No: 60.6% (n=20)	
How long into abuse did you access services?	*Not many survivors answered this question but* where they did, the majority said it was between 1-3 years into the relationship. 1 survivor noted 10+ years before they accessed services.	

What services did you access?	Again - not many survivors answered this question *but where they did,* <u>in order of prevalence:</u> • 66.7%(n=6) had accessed **domestic violence specialist services** • 44.4% (n=4) had accessed **children or adult social care** • 44.4% (n=4) had accessed support from **housing** - association/homeless support • 44.4% (n=4) had accessed support from the **Police or other CJS professionals** • 33.3% (n=3) had accessed support from the **council housing office** *Only 1 survivor (/9) mentioned going to health services, 0 mentioned mental health services.*	Again, a high proportion of survivors reported going to the police. We can take from this that survivors may be at crisis moments before they feel able to reach for support. This might suggest a lack of intervention in other services survivors access prior to needing police involvement. A very low proportion of survivors report using health services (0 mental health). This suggests a poor level of identification and support in health services, or that survivors do not think they will get the help they need in health services.
Attitudes towards support:	Only 8 respondents: *generally positive* • 75% (n=6) agreed or strongly agreed that they **felt able to ask for the help they needed** • 75% (n=6) agreed/strongly agreed that **were confident they would be believed** (25% [n=2] disagreed) • 62.5% (n=5) agreed/strongly agreed that **they knew where to go for help and support**, 25% (n=2) neither agree nor disagree, 12.5% (n=1) disagreed	The highest level of negative attitudes was related to 'where to go for support' and whether people will be believed. One survivor noted finding Bridges hard to contact and access, but another shared that Bridges had been amazing. One survivor shared how blame and self-blame act as a barrier to support where survivors feel the abuse is their fault. This same survivor

	<u>Quote:</u> *I didn't think anyone would believe the abuse I was getting from my ex husband. Mainly because he made me believe that everything was my fault. I always believed DV was where you got hit, but it's much more than that, and maybe I would have asked for help years ago had that information been made available.*	also suggested that non-physical abuse was not something they themselves had recognised prior to leaving.
Barriers to help seeking:	<u>In order of prevalence:</u> ● **I was worried about the consequences** from the perpetrator or the services I approached: 58.8% strongly agreed (n=10). ● **I didn't know where to go for help and support**: 47.1% (n=8) agreed or strongly agreed - so nearly 50%, 29.4% (n=5) neither agree nor disagreed, 23.5% (n=4) disagreed/strongly disagreed Least significant barrier: **I didn't feel safe enough** to get help or support: majority disagreed: 58.8% (n=10) <u>Quotes:</u> ● *shame, fear, danger and isolation from perpetrator* ● *I did reach out for support in 2019. I was living in Manchester at the time and moved to Tameside in April 2019. I was referred to Bridges from Manchester Womens Aid at this time. A case worker visited me twice*	The most significant barrier to help seeking was identified as fear of repercussions. More people identified not knowing where to go for help and support as a barrier than not. Where survivors elaborated, additional barriers included: ● **Lack of aftercare:** The second quote listed suggests a lack of aftercare and a lack of understanding around post-separation abuse (which is now in law due to new DA Act) ● **Fear of repercussions:** unsure of the outcomes of support (*suggests need for more clarity around pathways where abuse is reported)* ● **Shame:** *victim-blaming (not*

	in my home in Tameside but support then ceased as she said that she could not continue to offer a service as there was no continuing abuse as I was now separated from my husband and living alone. The abuse did continue, in spite of the separation and the dynamics of bullying and control continued, albeit at more of an arm's length. • *I present as a capable person and I think this signalled to the worker that my case need not be a priority.*	*presenting as 'perfect victim')* • **Not recognising abusive behaviour:** *2 survivors noted this*
Survivor experiences of support	**Lack of mental health support**: *(quote) There is a lack of mental health support available both short and long term. I have PTSD and can non access the therapy I need in Tameside via Pennine Care/Healthy Minds so pay privately which is not an option for all. I attended the Freedom Programme and found it very difficult as most on the course were there at the request of their social worker to enable them to have access to/retain care of their children which unbalanced the course.* **Financial abuse:** *(quote) As a disabled person, I have limited financial means, am reliant on disability benefits and have no means of ever getting rid of this debt.* **The police** *(quotes)*	The lack of mental health support is evident in the first quote. This is backed up by statistics later in analysis relating to the need for more mental health support. Financial abuse was discussed by two survivors, highlighting the economic impact of leaving abuse, and the need for more targeted support around debt and support and support to buy white goods. (tied to housing). One survivor also highlighted the additional financial burden on Disabled survivors. Two negative responses were shared regarding police intervention. One response was related to slow

	• *The police are very slow to come back with updates and take matters to court* • *On seeking support from the police there was a different response each time the police attended. There were times I felt I was in the wrong for seeking help from the police.* **Praise for Bridges** *(quotes)* • *Bridges are a godsend, they really did and are still helping me understand my abuse and how to take the next step. I do think there should be more surrounding when your abuser gets arrested though and what to expect.* • *Bridges has been very supportive and helped me a lot dealing with domestic abuse and offered mental health help, the freedom programme and also legal aid through a solicitor. I think this is a very important issue that needs to be funded* **Need for aftercare:** *(quote) I was discharged from the Tameside service much too soon, because there was apparently no continuing abuse. That does not reflect a good understanding of how abuse operates- it doesn't just stop because a relationship ends, and more to the point, the psychological and emotional damage caused doesn't just suddenly reverse, which*	responses, and another to receiving different responses each time. This is especially crucial considering the relatively high rates of survivors turning to the police for support in Tameside. A number of responses throughout the survey praised the response of Bridges, highlighting the educational aspect of their support, alongside the offer of mental health support, legal support and the freedom programme. Despite this, there were also two negative responses highlighting the lack of aftercare. The finding related to lack of aftercare suggests a potential lapse in the understanding relating to domestic abuse and the nature of perpetration (risk when someone leaves, post separation abuse). This is especially important to consider as the new DA Act brings in statutory acknowledgement of post-separation abuse.

	leaves a woman very vulnerable to returning to the abusive relationship, or entering into another controlling dynamic because they haven't had the help to understanding the dynamics at plan and have proper help with self worth and self esteem.	
How important do you think the following areas are in terms of future awareness raising/campaign activities in Tameside?	<u>In order of prevalence:</u> ● **Understanding emotional abuse/coercive control**: 100% (27), important, of which 96.3% (26) very important ● **Understanding the impact of domestic abuse on children**: 100% (27) important, of which 88.9% (24) very ● **Awareness raising that anyone can be a victim of domestic abuse (e.g. regardless of age, gender, sexuality, ethnicity, religion):** 100% (27) important, of which 85.2% (23) very ● **Understanding the mental health impact of abuse:** 96.3% (26) important, of which 85.2% (23) very ● **Awareness raising for friends/family around recognising when someone is being abused and how to support them**: 96.3% (26) important, of which 85.2% (23) very ● **Understanding financial/economic abuse:**	Survivors overwhelmingly agreed that more awareness raising was needed around emotional abuse. Survivors agreed there needed to be more awareness around the fact that anyone can be a victim. Again, the mental health impact and impact of abuse on children were also considered highly important in relation to the need for more understanding and awareness. The need for an awareness campaign around financial abuse was deemed highly important. This is important considering the new Domestic Abuse Act and definition including financial abuse. Again, a focus on the perpetrator was still considered very important, but comparatively the least important (as with the question about responses

	96.3% (n 26) important, of which 74.1% (20) very • **Awareness raising for perpetrators around recognising their own behaviours:** 92.6% (25) important,of which 88.9% (24) very	and holding perpetrators accountable). This may suggest that survivors wish to be centred and supported first.

Analysis of survivor demographics: can we identify any differences in response?	
Under 18s (n=3, only 2 answered follow up questions)	• 100% (n=2) of those under 18 reported emotional abuse, and all reported this from a family member. • Both respondents of this age (n=2) also noted using the internet to identify their experiences as abusive. • Being clear about confidentiality was significantly more important to this age group (100% noted it was very important when accessing services), as was holding the perpetrator accountable (100% noted it was very important)
Male survivors (n=6, only 2 responded to follow up questions)	• 100% (n=2) had faced physical and sexual abuse, as opposed to 50% emotional abuse. • No male respondents reported partner/spousal abuse. Instead, one reported abuse from a family member, one from a carer. • No male survivors reported going to the police for support.
Black and minoritised survivors (aggregated any non-white survivors) (n=6)	• No Black and Minoritised survivors reported speaking to a friend about their abuse. • 33% (n=1) had accessed support for the abuse they had faced in the last year. Slightly lower than the average rate across the survey.
LGBTQ survivors (n=6)	• This cohort reported high rates of mental health disability: 100% (n=4)

	• This cohort reported elevated rates of emotional abuse 83.3% (n=5) in comparison to the average rate across the survey. • Higher rates of violence from family members: 33% (n=2) partner violence, 83.3% (n=7) family violence (one survivor had experience both) • 83.3% (n=5) had identified abuse through a conversation with a health professional, significantly higher than the survey average. • 66% (n=2) strongly agreed they couldn't access the support they wanted (because, for example, it was too far away, didn't have childcare, wasn't accessible for someone with my physical disabilities and didn't have access to an interpreter/member of staff who speaks my language). This suggests additional barriers for LGBTQ survivors.

Simple cross analysis of the survey also provided insight into the difference in responses between survivors. Some key areas of difference are highlighted in the chart below, and provide grounds for the need for tailored and person-centred responses to abuse.

Analysis by survivor demographics	
Under 18s (3 respondents, only 2 answered follow up questions)	• 100% of those under 18 reported emotional abuse(n=2), and all reported this from a family member. • Both respondents of this age also noted using the internet to identify their experiences as abusive. • Being clear about confidentiality was significantly more important to this age group (100% noted it was very important when accessing services), as was holding the perpetrator accountable (100% noted it was very important).
Male survivors (6 respondents, only 2 responded to follow up qs)	• 2 respondents -100% physical and sexual abuse, as opposed to 50% emotional abuse. • 2 respondents - no partner/spousal abuse, one from a family member, one from a carer. • No male survivors reported going to the police for support.
Black and	• No BME survivors reported speaking to a friend about their abuse.

minoritised survivors (aggregated any non-white survivors) (n=6)	• 33% (n=1) had accessed support for the abuse they had faced in the last year. Slightly lower than the average. • Findings around barriers/service access very similar to average.
LGBTQ survivors (n=6)	• Higher rates of mental health disability: 100% (n=4) • 83.3% (n=5) had experienced emotional abuse • Higher rates of violence from family members: 33% (n=2) partner violence, 83.3% (n=7) family violence (one survivor had experience both) • 83.3% (n=5) had identified abuse through a conversation with a health professional. (much higher than average) • 66% (n=2) strongly agreed they couldn't access the support I wanted (because, for example, it was too far away, didn't have childcare, wasn't accessible for someone with my physical disabilities, didn't have access to an interpreter/member of staff who speaks my language)

Appendix 4 – List of Tables

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- Table 5: Bridges Performance data collected by Tameside Metropolitan Borough Council for 20/21
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- Table 8: PHE published statistics on mental health needs across England, Tameside and closest statistical neighbours (mixed years data)
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- Table 11: Tameside MARAC referral sources – unpublished data provided to AVA by Tameside domestic abuse performance management team, compared with national MARAC dataset available on Safe Lives website
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- Table 15: Tameside unpublished data on CSC assessments with domestic abuse (other person) recorded as a factor
- Table 16: proportion of CSC assessments in Tameside recording parental domestic abuse (unpublished data)
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- Table 18: domestic abuse notifications received from Greater Manchester Police demonstrating known cases vs new information (unpublished data)
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- Table 20: Bridges data from January 2020 – March 2021 on the nature of relationship between perpetrator and the victim-survivor
- Table 21: gives an indicator of the age of perpetrators known to Bridges service for the year Jan 2020: March 2021
- Table 22: Shows Bridges (unpublished data) analysis of the living arrangements of the perpetrators that they are aware of during the time period Jan 2020 – March 2021

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