

Profile of Repeat Victimisation within Multi-Agency Referrals.

ABSTRACT:

To help reduce victimisation, safeguarding practices in England and Wales are becoming more multi-agency, with Multi-Agency Safeguarding Hubs (MASH) being a contemporary example of such an approach. MASH aims to reduce victimisation by identifying and managing vulnerability at the earliest opportunity. This is achieved through the co-location of safeguarding agencies, joint decision-making and the co-ordination of interventions. Previous research has indicated that the demand placed upon MASH often outweighs available resources, questioning the extent to which MASH effectively safeguards vulnerable people at the earliest opportunity. Whilst existing literature has focused upon the characteristics of MASH referrals, alongside referral processes, rates of repeat referrals have been overlooked. This paper aims to bridge this gap by exploring the number of repeat referrals made over a two-month period to a MASH location in the North West of England (n=2,134). By investigating repeat referrals, reasons to why some individuals are susceptible to being victimised on multiple occasions are identified. The paper concludes that whilst MASH has taken a step towards identifying and managing victimisation, practices and processes need to be reviewed if MASH is to proactively prevent repeat victimisation.

KEY WORDS

Multi-agency safeguarding hub; safeguarding; victimisation; vulnerability.

INTRODUCTION

Multi-Agency Safeguarding Hubs (MASH) have been introduced to safeguarding practices across England and Wales as a means of identifying and managing vulnerability at the earliest

opportunity (Dunne and Finalay, 2016). In the context of MASH, 'vulnerability' relates to children and adults who are at risk of being exposed to harmful or abusive situations, such as sexual, physical and mental abuse, neglect and domestic abuse. To reduce the likelihood of vulnerable individuals being repeatedly exposed to risky situations, MASH co-locates a range of services, namely the police, children and adult social services, health, mental health and education (Jeyasingham, 2017; Authors, 2019). By co-locating these services, a secure environment is created that enables practitioners to share information more freely. Through this process a more holistic understanding of an individual or situation emerges, increasing the likelihood of decisions not only being jointly agreed upon, but proportionate and appropriate. However, the way in which local authority areas in England and Wales have embedded a MASH framework into safeguarding practices and processes is not consistent, making it difficult to identify best practice.

[Authors (2019)] investigated the characteristics of referrals made to a MASH location in the North West of England, with their work concluding that whilst MASH has taken a step towards a multi-agency approach to safeguarding, the demand placed upon MASH often outweighed resources. This finding questioned MASH's ability to identify and manage vulnerability at the earliest opportunity. To build upon the findings of [Authors], this paper aims to examine MASH's capacity to reduce levels of repeat victimisation. The paper will discuss findings from previous MASH studies, before investigating the risk factors associated with repeat referrals made to a MASH location in the North West of England.

LITERATURE REVIEW

MASH has been a feature of safeguarding practices since 2010, with policy, guidelines and research typically focusing upon what constitutes a MASH and the initial benefits of

implementing a MASH framework into every day safeguarding practices (Allen and Wilde, 2013; Home Office, 2014). For instance, Golden and colleagues (2011) looked at the impact MASH had made to safeguarding processes within Devon. Within their report, it was concluded that MASH had increased multi-agency collaboration by co-locating key safeguarding agencies (including police, social care and health), enabling decisions and interventions to become more effective and efficient. By increasing agency collaboration, Golden and colleagues noted that more safeguarding concerns were being identified and acted upon earlier, suggesting MASH has the capacity to proactively safeguard vulnerable individuals. Similar benefits were found by Crockett and colleagues (2013), who reviewed MASH frameworks within London. Specifically, they found that traditional silo practices were being replaced with more inter-agency practices, allowing referrals to not only be processed much quicker, but for decisions to be more effective. Thereby, Crockett and colleagues argued that MASH had reduced the likelihood of individuals being repeatedly exposed to risky situations. For both studies, data was primarily collected via practitioner interviews and general observations, overlooking the type of demand placed upon MASH, alongside MASHs capacity to reduce repeat victimisation.

Recently, [Authors (2019)] adopted a quantitative approach to investigate the characteristics of referrals made to a MASH in the North of England, with practices and processes of this MASH seeming to differ from those implemented in Devon and London. Their research concluded that demand placed upon MASH was influenced by static and dynamic risk factors, including age, gender, ethnicity and relationship status. The time taken for a referral to be processed by MASH was also explored, with the average processing time being 10 days. This finding not only contradicted the notion that all referrals to MASH would be processed within a 72-hour timeframe, but also the belief that MASH has the capacity to

identify and manage vulnerability at the earliest opportunity. Such disparity in findings demonstrates that whilst the theoretical benefits of implementing a MASH have been widely documented, the extent to which they transfer into every day safeguarding practices have not.

To gain a holistic understanding of whether MASH can identify and manage vulnerability at the earliest opportunity, the demand placed upon MASH, particularly re-referral rates, needs to be examined in more detail. Reasons for this are twofold. First, research relating to victimisation demonstrate that if an individual is the victim of crime once, specifically abuse or neglect, they are at an increased risk of being victimised again, with subsequent incidents tending to increase in frequency and severity (Messman-Moore and Long, 2003; Strøm *et al.*, 2017). Moreover, repeat victimisation not only has a negative effect upon an individual's physical and mental wellbeing (Graham-Kevan *et al.*, 2015), but it also increases the demand placed upon agency resources, specifically the police and social services. Secondly, to reduce such demand upon resources, multi-agency approaches, including MASH, were devised. A primary aim of MASH is to manage vulnerability at the earliest opportunity through the implementation of an appropriate and proportionate intervention. Thus, if an individual is being repeatedly referred to MASH, questions around who they are and reasons for their repeat victimisation need to be answered. The purpose of this research therefore, is to address some of these questions by examining repeat referrals to one MASH site in the North West of England.

METHODOLOGY

Data Analysis.

Data relating to referrals made to a North West MASH site, over a two-month period, was extracted from police systems, with 7,753 referrals being identified. Of these 7,753 referrals, 28% (n=2,134) of referrals were identified as being repeat referrals. For this study, a repeat referral involves a victim (defined below), being referred to MASH on two or more occasions during the chosen timeframe. All referrals to this MASH are made by the police, with the police making the final decision as to what should happen to a referral once all information is collected. Referrals occur when a police officer attends an incident, conducts a force specific risk assessment and identifies at least one individual to be vulnerable. On the referral form, an officer is required to complete a set of standardised questions, with answers based upon responses provided by the individual and an officer's interpretation of that situation. Referral forms capture demographic information relating to the victim and person suspected of causing harm (suspect), as well as details of the situation and reasons to why the victim was deemed to be vulnerable.

Unlike other MASH sites, this MASH processed cases relating to children (victim aged 17 or younger), adults (victim aged 18 or older) and domestic abuse situations. Domestic abuse referrals involved individuals aged 16 or older, who have been the victim of harm or abuse by an intimate partner or family member (HM Government (UK), 2016). If a domestic abuse incident involves children, it is referred as a domestic abuse case, with additional vulnerabilities being documented. Thus, all referrals are unique and only referred for one primary reason. During this research, it was noted that some repeat victims were associated

with different event descriptions, for instance a domestic abuse referral and then an adult referral. A mixed referral variable was created to capture such cases.

Once an event description has been identified, the referring police officer conducts a risk assessment, with guidelines produced by the local police force used to identify the level of risk (high, medium or standard) associated with an incident. High risk cases indicate that a victim *is*, or *has been*, exposed to significant harm, with referrals having a four-hour processing timeframe. If there is the *potential* for a victim to be subjected to significant harm, a case is deemed to be of medium-risk, with these cases having a 24-hour processing time. Standard risk referrals suggest that there is *concern* for a victim's health or well-being, with such cases given 72-hours to be processed. The processing of a MASH referral begins once this information is recorded and a referral to MASH is made. It is the information recorded on MASH referral forms that is analysed within this study, however, recording practices were not consistent, with some cases missing data.

Information recorded on a MASH referral includes the gender (male, female, unknown), date of birth and ethnicity (Asian, Black, Other, White, Unknown) of the victim and suspect, alongside the relationship between the two parties. For example, partners, son/daughter or neighbour, with these relationships being grouped into partner/ex, family members or other. Due to the age of the victim or suspect not being recorded, age had to be calculated by subtracting the date the case was recorded by the police away from an individual's date of birth. Referral reasons are also documented on a referral, with such reasons including child sexual exploitation, physical abuse, forced marriage and missing from home. When making a referral, the referring officer can select one or more relevant options.

All information relating to demographic characteristics, including gender, were pre-coded by the police, with the analysis reflecting the information available.

In addition to analysing the general characteristics of the 2,134 repeat referrals, 80 referrals (27%) were selected for further examination. To ensure cases were representative of the dataset, 20 cases from the four event descriptions were randomly chosen using a number generator. By focusing upon a smaller proportion of cases, the number of times a victim was referred to MASH could be examined, alongside those factors that contributed to a victim being repeatedly exposed to harm or abuse. For each case, general demographic information of victims and suspects associated with each case was recorded. To explore rates of repeat referral, the number of times a victim was referred to MASH during the chosen timeframe was reported. The number of days between a victim's first and last referral to MASH during the chosen timeframe was also recorded, alongside how many times the victim had been referred to MASH six-months after the chosen timeframe.

Situational factors, including occupation, identification of a mental illness, the presence of drugs and/or alcohol, were also reported for each referral. The reason to why a referral was made to MASH was explored, with the decisions made for each referral also being included in the analysis. Decisions generally involved a referral to a specific safeguarding agency, including health, education, police or mental health services. In some cases, a decision of 'step up' or 'step down' may also be recorded. If a case is 'stepped up' further assessment or intervention is required, with agencies required to share information as soon as possible. Conversely, if a case is 'stepped down', it is passed onto a relevant service for monitoring, with no immediate action needing to be taken. If no further action is required, a case cites a decision of no further action (NFA).

Data Analysis.

Inferential statistics were calculated using SPSS, allowing the interaction between the various variables to be identified. Data was normally distributed, enabling parametric tests to be used. Categorical data was investigated using Chi-square tests, with one-way analysis of variance (ANOVA) tests used to explore interval data that had three or more levels to the independent variable.

FINDINGS.

Descriptive Overview of Repeat Referrals.

Over the two-month period, 7,752 referrals were made to MASH, with 28% (n=2,134) of these referrals involving a victim who was referred to MASH on two or more occasions. Of the repeat referrals, domestic abuse cases accounted for just under half of all referrals (n=516, 49%), with 25% of referrals relating to children (n=516). Adult referrals represented 16% of referrals (n=342), whilst mixed referrals amounted to 10% of all repeat referrals (n=221).

A total of 910 unique victims were associated with the 2,134 repeat referrals. Victims were predominantly female (n=612, 70%), average age of 31 years (SD=18.93) and from a white ethnic background (n=805, 92%). There were 1,016 suspects linked to the 2,134 repeat referrals, with most suspects being male (n=762, 77%), mean age of 33 years (SD=12.99) and from a white ethnic background (n=840, 87%). A relationship of partner/ex was recorded on 50% of repeat referrals (n=510), with 2% of cases reporting a stranger (n=20).

During the two-month period, over three quarters of victims (n=710, 78%) were referred to MASH on two occasions, whilst 14% of victims (n=129) were referred on three

separate occasions. Around 8% of victims were referred to MASH on four or more occasions (n=71), with one victim referred ten times (<1%).

Demographic Characteristics of Repeat Victim Sample.

To investigate the characteristics of repeat referrals further, 80 cases were randomly selected, with Table 1 providing an overview of victim (n=80) and suspect (n=94) characteristics associated with these cases. The only significant findings related to the age of victims and the relationship between victim and suspect. A one-way ANOVA found that adult victims (M=54 years, SD=18.18) were significantly older than child (M=11 years, SD=5.22), domestic abuse (M=35 years, SD=10.57) or mixed (M=41 years, SD=17.99) victims, ($F(3, 76) = 33.09, p < .001$).

A relationship status of partner or ex-partner was cited on 37% of cases (n=34), with a significant association between event description and relationship status observed, ($\chi^2(9) = 87.063, p < .001, \text{Cramer's } V = .559$). Child victims were most likely to be harmed or abused by a family member (n=19, 73%), whilst over half of adult victims (n=9, 53%) were harmed or abused by someone known to them (other), but who was not a family member or romantic partner. Domestic abuse (n=20, 80%) and mixed (n=14, 56%) referrals mainly cited a relationship status of partner or ex-partner.

Table 1: Victim and Suspect Characteristics of Case Studies by Event Description.

Variable	Event Description				
	Child	Adult	Domestic Abuse	Mixed	All Cases
Victim Characteristics					
Gender	<i>N</i> =19	<i>N</i> =20	<i>N</i> =20	<i>N</i> =20	<i>N</i> =79
Female	11 (58%)	13 (65%)	17 (85%)	16 (80%)	57 (72%)
Male	8 (42%)	7 (35%)	3 (15%)	4 (20%)	22 (28%)
Age (Years)*	<i>N</i> =20	<i>N</i> =20	<i>N</i> =20	<i>N</i> =20	<i>N</i> =80
Mean	11 (SD=5.22)	54 (SD=18.18)	35 (SD=10.57)	41 (SD=17.99)	35 (SD=20.98)
Ethnicity	<i>N</i> =16	<i>N</i> =20	<i>N</i> =19	<i>N</i> =19	<i>N</i> =74
Asian	-	1 (5%)	2 (11%)	1 (5%)	4 (5%)
White	16 (100%)	19 (95%)	17 (89%)	18 (95%)	70 (95%)
Suspect Characteristics					
Suspects per Case	<i>N</i> =20	<i>N</i> =20	<i>N</i> =20	<i>N</i> =20	<i>N</i> =80
0	5 (25%)	14 (70%)	-	-	19 (24%)
1	5 (25%)	2 (10%)	15 (75%)	14 (70%)	36 (45%)
2+	10 (50%)	4 (20%)	5 (25%)	6 (30%)	25 (31%)
Mean Number of Suspects	1 (SD=0.98)	1 (SD=1.59)	1 (SD=0.41)	1 (SD=0.58)	1 (SD=1.00)
Gender	<i>N</i> =26	<i>N</i> =16	<i>N</i> =25	<i>N</i> =25	<i>N</i> =92
Female	11 (42%)	5 (31%)	4 (16%)	6 (24%)	26 (28%)
Male	15 (58%)	11 (69%)	21 (84%)	19 (76%)	66 (72%)
Age (Years)	<i>N</i> =26	<i>N</i> =17	<i>N</i> =25	<i>N</i> =25	<i>N</i> =93
Mean	31 (SD=12.38)	36 (SD=13.04)	39 (SD=12.55)	42 (SD=20.88)	37 (SD=15.61)
Ethnicity	<i>N</i> =24	<i>N</i> =15	<i>N</i> =24	<i>N</i> =25	<i>N</i> =88
Asian	1 (4%)	2 (13%)	-	2 (6%)	5 (6%)
White	23 (96%)	13 (87%)	24 (100%)	23 (92%)	83 (94%)
Relationship*	<i>N</i> =26	<i>N</i> =17	<i>N</i> =25	<i>N</i> =25	<i>N</i> =93
Partner/Ex	-	-	20 (80%)	14 (56%)	34 (37%)
Family	19 (73%)	2 (12%)	5 (20%)	7 (28%)	33 (35%)
Other	7 (27%)	9 (53%)	-	4 (16%)	20 (22%)
Stranger	-	6 (35%)	-	-	6 (6%)

**p* < .001

NOTE: Unknown Cases Removed from Analysis

Re-Referral Rate of Repeat Victim Sample.

Across the eight-week time frame, the sample of 80 repeat victims were referred to MASH a total of 217 times, with the average number of referrals being three (SD=1.39). This trend was similar across all event descriptions.

A significant association between event description and risk level was observed, ($\chi^2(18) = 35.65, p < .05, \text{Cramer's } V = .385$). Child cases were predominantly referred as high or medium risk cases ($n=8, 40\%$), whilst 35% of adult cases were referred as a standard risk level ($n=7$). Over half of domestic abuse cases ($n=11, 55\%$) were identified as medium or standard risk, with 40% of mixed ($n=8$) referrals also reported to be medium or standard risk.

The average number of days between these victim's first and last referral to MASH (during the eight-week timeframe) was 18 days ($SD=18.43$). Child victims ($M=7$ days, $SD=10.40$) were re-referred to MASH significantly quicker than domestic abuse ($M=25$ days, $SD=19.69$) and mixed ($M=23$ days, $SD=18.87$) victims, ($F(3, 76) = 4.641, p < .05$).

The minimum number of days between referrals was found to be zero. When this finding was investigated further, it was found that the recording practices used by MASH may unintentionally increase the number of times a victim features on the MASH database. For instance, 19% of victims were re-referred to MASH on the same day ($n=15$), suggesting some victims were harmed or abused numerous times within a 24-hour period.

However, this assumption is misleading, since further exploration found those cases, involving more than one suspect, a MASH referral had been submitted per suspect rather than unique incidents. For example, a victim in an adult case was referred to MASH four times in one day. Rather than these referrals relating to four different harmful or abusive incidents, the same referral form was referred four times due to it involving four different suspects. Thus, the victim was not repeatedly referred to MASH during the chosen timeframe but harmed or abused by multiple suspects on the same day. Subsequently, the notion that 19% of victims were repeatedly referred to MASH in a 24-hour period was misleading, with recording practices inadvertently increasing referral rates.

Six-months after a referral, 40% of victims were re-referred to MASH ($n=32$). Subsequent referrals ranged from one to 13, with the average number of re-referrals being 3 ($SD=2.58$). Domestic abuse ($n=11, 55\%$) and mixed ($n=11, 55\%$) victims were significantly more likely to be re-referred to MASH ($\chi^2(3) = 7.91, p < .05, \text{Cramer's } V = .315$).

Situational Factors Associated with the Repeat Victim Sample.

By focusing on 80 specific cases, it was possible to investigate the situational characteristics of referrals in more detail, enabling a more holistic understanding of repeat victimisation. There was a significant association between event description and victim occupation, ($\chi^2 (6) = 49.28, p < .001, \text{Cramer's } V = .562$). Adult ($n=12, 60\%$), domestic abuse ($n=13, 65\%$) and mixed ($n=13, 65\%$) victims were predominantly unemployed, whilst child cases were in education ($n=18, 100\%$). There was also a significant association between suspect occupation and event description, ($\chi^2 (6) = 13.57, p < .05, \text{Cramer's } V = .334$). A higher proportion of child suspects were unemployed ($n=14, 93\%$), compared to adult ($n=6, 75\%$), domestic abuse ($n=12, 60\%$) and mixed ($n=15, 83\%$) suspects.

Adult victims ($n=15, 75\%$) were significantly more likely to be identified as having a mental illness than victims associated with the other event descriptions, ($\chi^2 (3) = 25.11, p < .001, \text{Cramer's } V = .564$).

The presence of drugs, alcohol or both was reported on 40% of cases ($n=48$), with the relationship between event description and the presence of drugs or alcohol being significant, ($\chi^2 (9) = 18.41, p < .05, \text{Cramer's } V = .277$). A higher proportion of mixed referrals cited the presence of alcohol ($n=8, 40\%$), whilst 30% of domestic abuse cases recorded the presence of both alcohol and drugs ($n=6$). The main location for an incident to occur was the victim's home ($n=66, 86\%$), although a chi-square test found a non-significant interaction between event description and location of abuse ($p > .05$).

Referral Reasons and Decisions.

Over half of the case studies identified two or more referral reasons (n=42, 53%), with just under half of cases being repeatedly referred for the same reason (n=38, 47%). Table 2 depicts the reasons to why a referral was made to MASH, with a significant association between event description and referral reason being observed, ($X^2 (18) = 94.05, p < .001, \text{Cramer's } V = .626$). Child referrals primarily cited physical abuse (n=7, 35%), with 65% of domestic abuse referrals reporting verbal abuse (n=13). Mental health was the main reason adult (n=9, 45%) and mixed (n=8, 40%) referrals were referred to MASH.

Cases typically reported one or more decisions, with the relationship between some decisions and event descriptions being significant. Multiple chi-square tests found that child cases were significantly more likely to result in a referral to education (n=7, 35%), health (n=19, 95%), police (n=11, 55%) and YOT or probation (n=10, 50%) than the other event descriptions ($p < .05$). Likewise, a higher proportion of child cases were stepped up for further assessment (n=16, 80%), with a significant interaction between event description and a decision to step up a case being found, ($X^2 (3) = 25.05, p < .001, \text{Cramer's } V = .560$).

Various chi-square tests showed that domestic abuse cases were significantly more likely to result in a decision of 'other' (n=18, 90%) or multi-agency (MA) support (n=8, 40%), ($p < .05$). A referral to mental health services was primarily linked to mixed referrals (n=12, 60%), with this association also being significant, ($X^2 (3) = 26.24, p < .001, \text{Cramer's } V = .573$). Numerous chi-square tests found non-significant associations between event description and a decision of no further action (NFA), social care, step down or substance misuse ($p > .05$).

Table 2: Referral Reasons and Decisions Made by Event Description.

Variable	Event Description				
	Child	Adult	Domestic Abuse	Mixed	All Cases
Referral Reason**	<i>N=20</i>	<i>N=20</i>	<i>N=20</i>	<i>N=20</i>	<i>N=80</i>
Domestic Abuse	-	-	-	3 (15%)	3 (4%)
Mental Health	1 (5%)	9 (45%)	-	8 (40%)	18 (23%)
MFH	6 (30%)	1 (5%)	-	-	7 (9%)
Physical Abuse	7 (35%)	1 (5%)	7 (35%)	4 (20%)	19 (24%)
Sexual Abuse	4 (20%)	-	-	-	4 (5%)
Verbal Abuse	-	1 (5%)	13 (65%)	5 (25%)	19 (24%)
Other	2 (10%)	8 (40%)	-	-	10 (13%)
Decision	<i>N=20</i>	<i>N=20</i>	<i>N=20</i>	<i>N=20</i>	<i>N=80</i>
Education**	7 (35%)	-	3 (15%)	-	10 (13%)
Health*	19 (95%)	14 (70%)	15 (75%)	10 (50%)	58 (73%)
NFA	2 (10%)	3 (15%)	3 (15%)	5 (25%)	13 (16%)
Other**	-	3 (15%)	18 (90%)	17 (85%)	38 (48%)
Police*	11 (55%)	1 (5%)	9 (45%)	4 (20%)	25 (31%)
Probation/YOT*	10 (50%)	-	8 (40%)	4 (20%)	22 (28%)
MA Support*	-	1 (5%)	8 (40%)	4 (20%)	13 (16%)
Mental Health**	-	11 (55%)	2 (10%)	12 (60%)	25 (31%)
Social Care	16 (80%)	12 (60%)	12 (60%)	12 (60%)	52 (65%)
Step Down	3 (15%)	1 (5%)	3 (15%)	3 (15%)	10 (13%)
Step Up**	16 (80%)	3 (15%)	6 (30%)	3 (15%)	28 (35%)
Substance Misuse	1 (5%)	6 (30%)	3 (15%)	6 (30%)	16 (20%)

* $p < .05$, ** $p < .001$

Discussion

To better understand whether MASH reduces the likelihood of vulnerable people being repeatedly harmed or abused, this study explored the characteristics of repeat referrals made to one MASH location in the North West of England. The frequency and general characteristics of repeat referrals made to MASH over a 2-month period were initially explored ($n=2,134$), followed by a more in-depth analysis of 80 cases, enabling the demographic and situational characteristics of repeat referrals to be better understood. Through this process, a small proportion of victims accounted for a large proportion of MASH referrals, with this finding reflecting other crime victimisation trends (Pease *et al.*, 2018). Reasons to why some individuals are predisposed to being repeatedly referred to MASH will now be discussed in

more detail, including how recording practices inadvertently contributed to the prevalence of repeat referrals.

During the chosen timeframe, 28% of victims were repeatedly referred to MASH, with referral rates differing by the gender, age and ethnicity of the victim and suspect, alongside the relationship between the two individuals. Victims were predominantly female, whilst suspects were male, reflecting the notion that females are more vulnerable to be repeatedly victimised than males (HSCIC, 2014). Ben-David's (2000) conclusion that repeat victimisation may be the result of unequal power structures was also supported, since 80% of domestic abuse cases identified a relationship status of partner or ex-partner. This also emphasises the belief that victims of domestic abuse are at an increased risk of being repeatedly victimised, compared to other vulnerable populations (Bland and Ariel, 2015; Walby *et al.*, 2016).

For each event description (child, adult, domestic abuse and mixed) 20 cases were randomly selected and explored in more detail, with the general victim and offender demographic findings being replicated. Most cases stated that the victim and suspect were known to one another, with the abuse taking place in the victim's home. Demonstrating how dynamic factors, such as relationships and home environments, may contribute to an individual being repeatedly victimised. Therefore, if victimisation is to be prevented at the earliest opportunity, MASH needs to identify and address a range of interrelated factors, with interventions being directed towards households and families, rather than specific individuals. If such an approach is taken, the intergenerational nature of offending and victimisation, particularly in relation to children (Bartlett *et al.*, 2016; Flynn *et al.*, 2017), is likely to be disrupted, reducing the likelihood of individuals being exposed to risk situations in the future. By taking a holistic approach to identifying and managing vulnerability, the

demand placed upon safeguarding processes will decline, enabling limited resources to be directed to those most in need.

Various situational factors were found to be associated with the likelihood of an individual being repeatedly referred to MASH, with these factors having the potential to change. Employment was one such factor, with repeat referrals primarily identifying victims and suspects as being unemployed, increasing the likelihood of individuals sharing the same daily routine (Cohen and Felson, 1979). This finding generates other referral options, such as referrals to employment services, which would change an individual's daily routine, reducing the amount of time victims and suspects spend together in the same space.

Mental health, which can be changed through medicine and lifestyle, was also explored, with poor mental health being common amongst victims rather than suspects. Adult cases were most likely to identify a victim with mental health problems, alongside the absence of a suspect, reflecting the notion that individuals with a mental illness are at an increased risk of repeatedly exposing themselves to harmful situations (Manthorpe and Samsi, 2013). Whilst MASH may be able to refer individuals to mental health services, the complex nature of mental health issues may reduce the effectiveness of interventions, increasing the likelihood of some individuals being repeatedly referred to MASH. Conversely, less than half of all referrals reported the presence of alcohol and/or drugs, implying that whilst substance abuse may increase an individual's predisposition to being victimised (Meinck *et al.*, 2015), it was not a major factor amongst MASH referrals.

Just under half of all cases cited the involvement of a child, with this finding further evidencing the importance of holistically looking at a vulnerable situation. The involvement of a child ranged from witnessing a harmful or abusive incident, to a child living at the address

the incident occurred in. Domestic abuse referrals commonly cited the involvement of a child, with research highlighting how exposure to domestic abuse can increase the likelihood of repeat victimisation in both childhood and adulthood (McCallum and Peterson, 2016; Holt, 2017). If MASH is to prevent the cycle of repeat victimisation, interventions not only need to be implemented early, but extend beyond the immediate victim and suspect. For instance, interventions need to be directed towards children who may witness or live in abusive situations, with such interventions being sustained and monitored over a long period of time.

On average, victims were re-referred to MASH a total of three times within the eight-week period, supporting the notion that re-victimisation usually occurs within a short space of time (Lloyd *et al.*, 1994; Sagovsky *et al.*, 2007). Questions around MASHs recording practices were raised, since just under a fifth of victims were re-referred to MASH on the same day as their first referral. Further investigation revealed that referrals to MASH were based upon the number of suspects associated with a referral, rather than the number of victims or separate incidents. Recording practices, therefore, overestimated the number of times an individual was victimised, reflecting HMIC's (2015) finding that inadequate recording practises may prevent the police from providing accurate information regarding repeat victimisation. Subsequently, flaws within recording practices make it difficult to establish whether MASH is effectively reducing levels of repeat victimisation. This finding also demonstrates the importance of policy and decision makers not solely relying upon performance data when contemplating changes. Rather, decision-making processes should incorporate qualitative approaches, such as case studies and practitioner interviews, with a mixed method approach enhancing understandings of vulnerability trends and risk factors. Increasing the likelihood of interventions being proportionate and effective, further helping to reduce the demand placed upon safeguarding agencies.

Within a six-month follow up period, two-fifths of victims were re-referred to MASH, reflecting Babcock and DePrince's (2013) conclusion that once an individual has been victimised, they are at heightened risk of being re-victimised. When cases were re-referred to MASH, referral reasons were often the same, suggesting that whilst a case may be passed on to a relevant agency, appropriate interventions or continued monitoring, may not always be implemented. For instance, six-months after its initial referral to MASH, a mixed referral case was re-referred six times, with subsequent referrals relating to the victim being physically abused by the same suspect, as well as threatening to take their own life. At one stage, the suspect was given a court order preventing them from contacting the victim, with this order being breached on numerous occasions. Implying that whilst MASH makes safeguarding decisions, it potentially fails to monitor the implementation and effectiveness of such interventions.

By taking a multi-agency approach to identifying vulnerability, decisions made by MASH are more proportionate and appropriate, resulting in a variety of decisions being documented. The most prominent decisions were to share information with health services and social care, with only a small proportion of cases resulting in no further action. Due to most cases resulting in a referral to a relevant agency, MASH has taken a step towards a multi-agency approach to safeguarding society's most vulnerable individuals. However, the analysis was not able to determine what actions were taken by those agencies a referral was referred to, since once a case left the MASH system, further information was not recorded. Considering the high re-referral rate, it could be argued that whilst MASH may identify vulnerability early, it may fail to ensure it is managed at the earliest opportunity, increasing the risk of individuals being repeatedly victimised.

Conclusions

Repeat victimisation is a 'complex phenomenon' (Turanovic and Pratt, 2012: 47), with repeat victimisation being associated with both static and dynamic risk factors. Recently, safeguarding processes have taken a step towards a multi-agency approach to preventing victimisation, with the introduction of Multi-Agency Safeguarding Hubs (MASH) being an example. To understand why some individuals are susceptible to being victimised on multiple occasions, this paper explored the characteristics of repeat referrals to one MASH location in the North West of England. Through this process, demographic factors, including gender, age and ethnicity, as well as situational factors, such the presence of substances and location of abuse, were found to increase the likelihood of an individual being repeatedly referred to MASH. These findings exemplify the notion that victimisation is not random, but often the consequence of individual and environmental factors coming together at the same time (Cohen and Felson, 1979; Grove *et al.*, 2012).

The study also questioned the effectiveness of MASH recording practices, since processes distorted the rate at which individuals were re-referred to MASH. Equally, what happens to a referral once a decision is made was not monitored, potentially increasing the likelihood of an individual being re-victimised. Whilst MASH may reduce the likelihood of most individuals being re-victimised, MASH practices, as well as individual and situational characteristics, make it difficult for MASH to effectively safeguard all referrals from being repeatedly victimised.

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