Final Report for Yellow Door and Stop Domestic Abuse

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Authors: Dr Terri Cole, Chloe Smith, Dr Jane Healy, Dr Orlanda Harvey

Bournemouth University

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Abbreviations

ASC	Autistic spectrum condition
BME	Black and Minority Ethnic
BU	Bournemouth University
CDC	US Centre of Disease Control and Prevention
DA	Domestic Abuse
DV	Domestic Violence
FGM	Female Genital Mutilation
HBA	Honour Based Abuse
IDVA	Independent Domestic Violence Advisor
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Other (includes pansexual, omnisexual, demisexual, two-spirited, a-romantic)
MARAC	Multi-Agency Risk Assessment Conferences
ONS	Office of National Statistics

Table 1 - Abbreviations

Bournemouth University

Bournemouth University (BU) is situated on the south coast of England, in the County of Dorset, and has more than 19,000 students. We are ranked as one of the top 200 young universities in the world. Our research shapes and changes the world around us, providing solutions to real-world problems and informing the education we deliver. Our students are a key part of the research we conduct, co-creating knowledge with us and playing a crucial role in everything that we do. Our vision of Fusion brings together three key elements of education, research and practice, creating something which is greater than the sum of its parts. Through the impact of our research and education, and the contribution of our staff, students and graduates, we are able to deliver the third aspect of our purpose, to enrich society. It is this focus on Fusion which is reflected within this research project, as we value the interaction between academic research and front-line professional practice.

Acknowledgements

This work was done in partnership with Yellow Door and Stop Domestic Abuse. We are immensely grateful to all those who took part in the fieldwork, including the victims/survivors who answered the survey and took part in interviews, and also the professionals who took part in the focus group.

Executive Summary

This report outlines the research we have undertaken into the provision of domestic abuse (DA) services for individuals in Southampton and surrounding areas. This research was commissioned by Yellow Door and Stop Domestic Abuse, on behalf of Southampton City Council, and data collection took place late 2023 to early 2024.

Yellow Door are a specialist domestic and sexual abuse charity based in Southampton and provide specialist services across Southampton and Hampshire. Their services include a range of advocacy provision, therapy services, training, and maintaining a helpline.

Stop Domestic Abuse (Stop DA) provide a range of advice, support and information services for people affected by domestic abuse, including refuge, accommodation and community-based services in Hampshire, Portsmouth and Southampton. Services include advocacy, one to one and group work tailored to individual levels of risk and support needs.

Southampton City Council commissioned Yellow Door and Stop DA to deliver specialist advocacy services for bespoke groups of victims and survivors of domestic abuse. This included services for disabled communities and those from Black and minority ethnic ('BME') communities which Yellow Door was commissioned to deliver, and lesbian, gay, bi, trans, queer and other sexual orientation and identities ('LGBTQIA+') services delivered by Stop DA. The focus was to ensure specialist services were tailored and adaptable for these groups and recognise the bespoke needs they may have. Both organisations were required to deliver services to adult victims of domestic abuse in these communities, to raise awareness of domestic abuse and how to seek help and to working within the communities and with practitioners to investigate what their needs are in these areas. Further, they were required to deliver a review of current provision and carry out research to inform future commissioning of these services. Bournemouth University were commissioned to provide research to meet the following aims:

1. To yield a detailed review and recommendations about future delivery of work in this arena, based on the experiences gathered [from disabled, BME and LGBTQIA+ communities]
2. To ensure future commissioning of services for victims is informed by the experiences of the services provided, including identifying barriers and plans to reduce/remove those barriers.

The research was specifically designed to focus on support needs that may be required by those who have specific protected characteristics as defined by the Equality Act 2010, specifically: LGBTQIA+ communities, Black and Minority Ethnic communities, and disabled people. The data collected included an online survey completed by 317 people (212 living in the Southampton area). A focus group with professionals and two online interviews were also conducted with people having lived experience of DA from the Southampton area.

Key Findings

The findings from the survey, focus group and interview data are consistent overall, with several key themes emerging - summarised below in consideration of the aims above, and detailed further throughout the report:

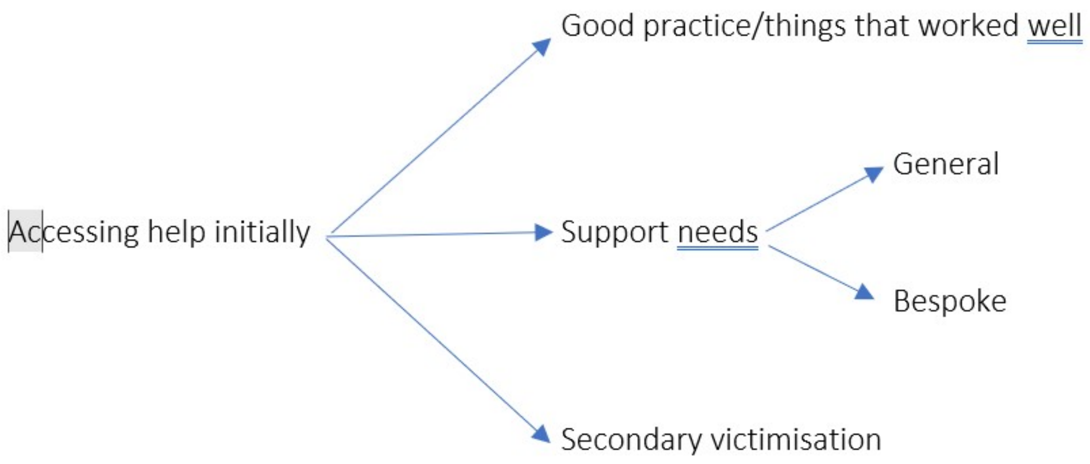

Figure 1 - Mapping of Overall Themes

- In consideration of future commissioning and delivery, many participants felt that a main barrier involved difficulties in accessing help initially – namely the availability of support should be enhanced as and when required in order to address the compounding and intersectional impact of DA. Specifically, respondents highlighted long waits for services which they needed sooner. Some of these waits had severe impacts on their mental and physical health. Some highlighted thoughts of suicide and/or returning to their abusive partner - for example *"I waited for so long... I had to find my own private counsellor as I could barely cope with living anymore" (Angelina, White Portuguese, heterosexual, non-disabled); "It would have been useful to get the support earlier - it came several months after the incident and I had a lot of low days while waiting, including thinking of taking the abuser back" (Nihal, Sri Lankan, heterosexual, non-disabled).*
- In terms of good practice and things which worked well, the majority of victims/survivors of DA found the support services offered to them were very useful or useful, with many giving examples of services which hugely assisted them, with impactive comments including for example: *"Without their support I would not have been able to leave and I would likely not be alive" (Fleur, European) and "support saved my life and I know that so please keep doing what you're doing and more, because there's people out there still going through it" (Angela, White British, lesbian, disabled).*
- In terms of delivery, general support needs were mainly in relation to accessing counselling or for their mental health, as well as some assistance in keeping safe and seeking advocacy.
- In relation to delivery and general support needs, users also wanted more frequent contact with support services, saying every other week was not enough, for example *"at least once a week would of helped more" (Isabel, White British, heterosexual, disabled).* Many who had experienced DA also highlighted the need for long-term support – as the trauma endured is on-going for years rather than weeks or months: *"Sessions need to be much longer… 12 or 14 or 16 most definitely are not… enough" (Enid, White British, heterosexual, disabled).*

- As well as general needs, in terms of future commissioning and delivery we considered the needs of bespoke communities. In particular it was recognised that:
    - LGBTIA+ groups may experience barriers due to lack of familial or local support, or inappropriate provision in refuges or shelters;
    - BME groups may face additional needs in relation to language services, no recourse to public funds, or cultural or familial barriers in help seeking;
    - Disabled groups may experience additional barriers in accessing services which need to be accessible and inclusive, and may face barriers in help seeking if their abuser is also their carer.
- There was a desire for tailored, bespoke support for people from the three groups, but not to the detriment of existing services for all victims/survivors of DA.
- In terms of future commissioning, this research also found another group which may require bespoke support are male victims/survivors.
- In terms of future delivery, the main barriers to accessing support for participants included: Embarrassment, stigma, or shame, such as *"I might be making a big deal and bringing shame" (Faiza, British Asian, heterosexual, non-disabled).* This was closely followed by fear of consequences, and not being believed, for example *"I was scared on what people would think and that no one would believe me" (Ivy, White British, heterosexual, disabled).*
- Another barrier to accessing support for many was they did not recognise the behaviours they were experiencing as abuse, were in denial or thought it was not a 'big deal'. As such future commissioning should consider how services can be better marketed to specific communities and encourage better training for professionals and awareness within the general public of what constitutes abuse in all forms, in order for it to be fully recognised.
- Instances of poor practice and secondary victimisation by statutory agencies responding to DA were highlighted as additional 'organisational' barriers when accessing support. For example there were many examples of victims/survivors being passed between different services including *"I got passed around, had to retell different people my story over again... I have seriously struggled to get the help I need" (Violet, White British, heterosexual, non-disabled).* As such improvements are required to enhance training for agencies, provide additional funding for support services, and research such as this, listening to the voices of service users and representing their views. A 'one stop shop' was suggested by one participant.
- In terms of future commissioning, many participants also highlighted a lack of available emergency and temporary housing stock which limits the ability of services to provide safe accommodation for victims/survivors, impacting their ability to leave their abuser.

Key Recommendations

- In terms of future commissioning it is strongly recommended that current delivery of services continue, and moreover are enhanced with increased provision going forward;
- In terms of commissioning, DA service providers should be adequately funded for long term investment, to enable them to deliver timely, specialist support at the point of need and reduce the risk of repeat victimisation;
- In terms of future commissioning support should be inclusive and accessible to all, and as such should consider additional barriers and bespoke needs some service users have - these may include but not be limited to the three communities specifically investigated;
- In terms of delivery, services should be person-centred, with the ability to be tailored to meet individual needs – in relation to specific considerations for LGBTQIA+, BME or disabled people. Delivery of those services by and for people with bespoke needs, is strongly recommended;
- In terms of future commissioning, enhanced awareness via training of agency professionals, (which can cause secondary victimisation), and the public (e.g. campaigns when victims/survivors are trying to reach out) is a significant need as these are significant barriers in accessing meaningful support;
- Moreover, awareness raising and marketing of DA services should consider the significant lack of recognition/denial of behaviours as abuse - which may be particularly apparent in some communities; services should note that if offering targeted support to certain communities, not all minority persons identify as such;
- In terms of future commissioning, funding for services should recognise the complexity of DA in terms of increased risk to mental health conditions and the intersectional nature of victimisation;
- Service providers must endeavour to identify accessible and empathic ways to ensure that when victims/survivors first contact them that not only are they are effectively supported and believed, but also that any actions or outcomes are clearly communicated to them so that they feel they have ownership and involvement in decisions.

Introduction

This report outlines the research we have undertaken regarding the provision of domestic abuse (DA) services for individuals. In particular it focuses on support required by those who are part of the three following communities, with specific protected characteristics as defined under the Equality Act 2010: LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Other [which includes pansexual, omnisexual, demisexual, two-spirited, a-romantic]), Black and Minority Ethnic (BME, which includes migrants, Black British and British Asian nationals), and disabled people. The data which informs this report is drawn from an online survey (N=317) with people predominantly from the Southampton area (n=212), a focus group with practitioners from Southampton and interviews with services users in Southampton. It considers current good practice and service provision, as well as identifying any barriers in service provision or engagement, and ways in which the services could be improved.

Yellow Door are a specialist domestic and sexual abuse charity based in Southampton and provide specialist services across Southampton and Hampshire. Their services include a range of advocacy provision, therapy services, training, and maintaining a helpline. In 2020/21 they directly supported 4,282 clients, this was an increase of 88% from the previous year and 182% from the year before that. As such demand for services are rapidly increasing.

Stop Domestic Abuse (Stop DA) provide a range of advice, support and information services for people affected by domestic abuse, including refuge, accommodation and community-based services in Hampshire, Portsmouth and Southampton. Services include advocacy, one to one and group work tailored to individual levels of risk and support needs.

Southampton City Council commissioned Yellow Door and Stop DA to deliver specialist advocacy services for bespoke groups of victims and survivors of domestic abuse. This included services for disabled communities and those from Black and minority ethnic (“BME”) communities which Yellow Door was commissioned to deliver, and lesbian, gay, bi, trans, queer and other sexual orientation and identities (LGBTQIA+) services delivered by Stop DA. The focus was to ensure specialist services were tailored and adaptable for these groups and recognise the bespoke needs they may have. Both organisations were required to deliver services to adult victims of domestic abuse in these communities, to raise awareness of domestic abuse and how to seek help and to working within the communities and with practitioners to investigate what their needs are in these areas. Further, they were required to deliver a review of current provision and carry out research to inform future commissioning of these services. Bournemouth University were commissioned to provide the research to meet the following aims:

1. To yield a detailed review and recommendations about future delivery of work in this arena, based on the experienced gathered [from disabled, BME and LGBTQIA+ communities]
2. To ensure future commissioning of services for victims is informed by the experiences of the services provided, including identifying barriers and plans to reduce/remove those barriers.

Background

Domestic abuse (DA) is defined as behaviour of one person to another (where both are over age 16) which is abusive (Domestic Abuse Act, 2021). This includes abuse which is physical, sexual, violent or threatening, psychological, emotional, economic, controlling and/or coercive behaviour. This includes single incidents or a pattern or behaviour, where individuals have a personal connection. 'Personal connection' means the individuals are due to be, currently, or have been married or civil partners, in an intimate relationship with each other or are or have been parents to the same child (NCVO, undated). Children are recognised as victims of domestic abuse if they experience the effects of abuse between two adults (over age 16).

Current crime statistics suggest that there has been an increase in reports and/or disclosure of DA (Office of National Statistics (ONS), 2022). It is estimated that 2.1 million people aged 16 years and over (1.4 million women and 751,000 men) in England and Wales experienced domestic abuse in the year ending March 2023 (ONS, 2023). Studies have also reported numerous barriers to accessing support including shame, difficulty recognising the abuse, and ongoing behaviour by the abuser (Couto et al. 2023, Heron et al. 2022).

DA occurs in all parts of society, however emergent research suggests that it is more prevalent within certain minority communities, such as: LGBTQIA+ (New Jersey Institute of Technology, 2022); BME (Interventions Alliance, 2021); and disabled people (Magowan, 2003). Despite this, little research either nationally, or locally has been conducted to date to investigate if there are bespoke needs of such communities.

Although DA support services are provided through statutory bodies i.e. Criminal Justice services, national health services and local authorities, the role of the charity sector should not be underplayed when it comes to supporting victims/survivors of DA, as they play a critical role in delivering best outcomes for service users (Ablaza et al. 2022). Therefore, it is incumbent on charities and non-governmental agencies to ensure they are using evidence-based information to ensure the support they provide is as effective as possible.

LGBTQIA+

As with many areas of the population, it is difficult to measure the prevalence of DA specifically within the LGBTQIA+ community as many victim/survivor statistics do not include demographic data regarding sexuality or gender identity; however, 1.4% of victims/survivors discussed within MARAC[1]s identified as lesbian, gay, bisexual or transgender (ONS, 2022).

Stonewall's national survey of the LGBTQIA+ community in the UK found up to one in four lesbian and bisexual women (25%) have experience of DA (Guasp, 2011). Significant findings were reported by Henderson (2003), who found 22% of lesbian respondents had experienced abuse at least once, and 61.9% had suffered reoccurring abuse. Hassouneh and Glass (2008) reported lesbian women felt they were fighting against various lesbian stereotypes, including some victims/survivors being arrested, because they were perceived as 'butch' or as traditionally more 'masculine' in their relationship. This highlights the problematic nature of gendered stereotypes in heterosexual encounters of DA, some of which are replicated in same-sex relationships.

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[1] Multi-Agency Risk Assessment Conferences – i.e. meetings where information is shared between agencies regarding the highest risk domestic abuse cases.

Gay men are one of the more researched groups within the LGBTQIA+ community, and evidence suggests they also experience profound levels of abuse within their relationships. Research by Stephenson et al., (2022) found 11.8% of gay men had reported experiencing physical violence and 4% had experienced coercion into sexual activities. One study of young gay men found 86% had been subject to psychological aggression, 67% had experienced physical assault, and 64% experienced sexual coercion (Kubicek et al., 2016). There are many potential reasons why there appears to be disparity between the reporting levels between studies due to different methods and samples involved, however the overall prevalence is nevertheless alarming.

Research highlights the abuse suffered by those in same sex relationships can be similar to that experienced by heterosexual individuals – for example encompassing a multitude of financial, physical, sexual and psychological abuse. However bespoke notions of masculinity, and assumptions regarding such relationships can act as barriers to disclosure or understanding. For example one study looking at experiences of gay men who have experienced intimate partner violence (Maxwell et al, 2022) found physical abuse may be ignored by society as features such as 'rough sex' may be perceived as 'normal' in such relationships. Moreover, victims with 'muscular' bodies may fear they are not believed or may minimise their abuse in order to avoid outward signs of physical weakness.

In relation to bisexual individuals, research by the US Centre of Disease Control and Prevention (CDC) found higher rates of DA were reported by bisexual people than by heterosexual, gay, or lesbian people (CDC, 2013). Specifically, they found that a lifetime prevalence for rape, physical violence, and stalking was evidenced by 61.1% of bisexual women and 27.3% of bisexual men. Bisexual individuals face the same barriers to gaining support for victimisation that occur throughout all parts of society, but Scheer et al. (2023) also found that for two of their participants (in a sample of 118), they did not seek help because they did not want to contribute to negative perceptions of the LGBTQIA+ community.

Trans is an umbrella term used to describe individuals whose gender is not the same as they were assigned as birth; and can incorporate many gender identities including transgender, non-binary and gender fluid. Most research into DA within the Trans community rarely differentiates between these subgroups, however Peitzmeier et al., (2020) found transgender individuals were around twice as likely to experience DA of a sexual or physical nature than their cisgendered counterparts. Other research in the US suggests between 30 and 50% of all transgender individuals have experienced DA (Brown & Herman, 2015). One study found more than two-thirds of female-to-male individuals had experienced DA within their lifetimes (McDowell et al., 2019).

In summary, much research does not record sexual orientation of victims/survivors and this in combination with under-reporting of DA more generally, means accurate levels of prevalence is unknown. However, from the research there is, it is clear DA is present in these communities, with some findings suggesting they experience higher rates of DA than their cisgendered and heterosexual counterparts.

BME

The acronym BME (Black and Minority Ethnic) refers to any individual that is not of white ethnicity - it does not refer to country of origin or affiliation (Mayor of London, 2018). According to data from the Crime Survey for England and Wales (ONS, 2023) a higher percentage of the victims/survivors of DA were described as BME (4.7% White, 7.9% Mixed, 3.5% Black or Black British, 2.0% Asian or Asian British). This may suggest that those who are from minority ethnic backgrounds are potentially at higher risk of victimisation. Equally, Iob et al.'s, (2020) UK study, using questions asking directly about physical and psychological abuse, found BME groups made up 12.5% of victims/survivors of psychological abuse and 4.3% of physical abuse. These percentages indicate victimisation is skewed towards the BME individuals in these samples.

In addition, "honour" based abuse (HBA) is believed to be more prolific within BME communities than that of White communities (Bates, 2021). HBA is loosely defined as a crime/incident which has been committed to protect or defend the honour of the family and/or community (*What is Honour-based Abuse?*, n.d.); it can exist in many forms, often involving coercive control. Behaviours can include female genital mutilation (FGM), forced marriage or abortion, and removing or restricting someone's freedom. The length of time victims endure abuse before seeking help is on average five years, nearly twice as long as those who were not identified as at risk of HBA (SafeLives, 2017). The research suggests this is likely to be attributable cultural sensitivities which encourage victims/survivors to keep such things 'within the family'.

SafeLives (2021), highlighted an increase in BME cases being discussed in MARACs; from 15.6% in 2020 to 16.6% of all cases in 2021. DA generally has lower rates of disclosure than that of other crimes, however, this increase suggests more individuals are now accessing support. However, previous research by SafeLives (2015) suggested that BME individuals take 1.5 times longer to seek help than those who identify as White (2.6 years for high risk and 3 years for medium risk incidents). This could be due to a variety of reasons, such as fear about what would happen if they left their abusive relationship (Hulley et al., 2023) and one issue mentioned repeatedly in research is the fear their children will be removed from their care (Anitha, 2008; AVA, 2022). Moreover, it is recognised there are a range of barriers for women accessing support for DA, and Hulley et al.'s (2023) study evidences that for ethnic minority women, these may be exacerbated.

In summary, research indicates women within the BME community may be more likely to experience DA. In addition, there may be bespoke barriers for such individuals seeking help, such as a belief that complex matters such as FGM or HBA should be dealt with in the family.

Disabled people

The term disabled person is defined as someone with "a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities" (Equality Act, 2010). Around 14.3% of disabled individuals in England and Wales have experienced abuse in some form (ONS, 2022) and according to the Crime Survey for England and Wales (ONS, 2019) women with any form of disability are twice as likely to experience abuse than their non-disabled counterparts. Specifically, disabled women were found to be 30% more likely to experience DA (Emerson et al., 2023).

The term disability covers a variety of different conditions, impairments and disorders and different disabilities impact differently upon the risks of experiencing DA. For example, Griffiths et al., (2019) found adults with Autistic Spectrum Condition (ASC) were nearly twice as likely to answer yes to having DA experience (compared to a control group of those without a diagnosis) in nearly all questions asked. They found sexual abuse was present in 20%, physical abuse was present in 30%, and financial abuse in 39% of autistic relationships. Equally research by Dell-Osso et al., (2018) suggested those who had disclosed a history of abuse showed higher scores on the adult autism subthreshold, and Roberts et al., (2015) found historic abuse was more prevalent in individuals with autistic traits.

Individuals with ASC are not the only disabled group that may be at a higher risk for DA. Research by Johnston-McCabe et al., (2011) found that up to 71.7% of hearing-impaired women had some experiences of psychological abuse. Similarly, Smith and Hope (2015) highlighted the unique experiences of hearing-impaired victims/survivors, showing that perpetrators use bespoke abuse techniques focused on controlling levels of contact with the outside world. Additionally severe mental illnesses are included under the disability definition. In research conducted on psychiatric inpatients (Choudhury et al., 2021), 21% of married patients had some experience of DA: 47.6% of those had depressive disorders, 9.5% had bipolar disorders and 2.4% had schizophrenia spectrum disorders. Similarly, work by Afe et al., (2017) found 73% of people with schizophrenia (of 79 individuals) had experienced at least one type of DA (71% verbal, 40% physical, and 19% sexual).

Within other disability communities DA is equally prevalent. According to the ONS (2022), 19.1% of individuals with learning disabilities had some experience of DA in the year prior to data collection. 38.2% of those with physical disabilities, according to research by Fanslow et al., (2021), had some experiences of physical abuse and 23% had experienced economic abuse. Additionally, according to Coles et al., (2022) at least 1 in 12 visually impaired individuals had experience of DA. Many of the participants cited their lack of sight as a factor in their abuse, with being unable to see the perpetrator leading to both direct and indirect emotionally abusive behaviours.

As such, there is significant evidence that disabled women are at increased risk of DA or interpersonal violence and assault (Balderston, 2013; Healy, 2021; Hughes et al., 2012; McCarthy, 2017; Pettitt et al., 2013; Thiara & Hague, 2013). For many disabled people, DA is more prevalent and can be even more difficult to escape from, for example when victims/survivors are reliant on their abuser for their care (Sin, 2015). Disabled women are more vulnerable to victimisation from those they are in a relationship with (Magowan, 2003) and additional, structural factors can prohibit them leaving their relationships, such as lack of accessible refuge provision (McCarthy, 2017; Thiara & Hague, 2013). These limited routes to safety, alongside a reliance on abusers for their care can mean disabled women are left with no choice but to stay in DA relationships for longer.

In summary, it appears that the three bespoke groups outlined above may be at more risk of DA. However there has been little consideration of whether general services for such individuals are sufficient, or if services considering bespoke needs of these different communities, are required. As such Yellow Door and Stop Domestic Abuse commissioned such research from Bournemouth University, with a focus on views and service provision in the Southampton area. The three research questions focussed upon were:

1. What are the support services currently doing well?
2. What could be improved by support services?
3. Do LBGTQIA+, BME or disabled people have specific support service needs?

Method

Three simultaneous studies were conducted to explore experiences and needs in relation to the three target groups – LGBTQIA+, BME and disabled people. The research used a combination of surveys targeting the general public (focussing on Southampton), a focus group with practitioners working in the field, and interviews with victims/survivors. Full ethical approval for all elements was obtained prior to data collection, in line with the BU ethical codes of conduct and the UKRI's research ethics framework. In line with good practice guidance, representatives from the commissioning organisations reviewed extensive drafts of the designs of the research, and approval was obtained from them prior to submission to the University's ethics panel.

Survey

An online survey was sent out to adults, focusing on those living in Southampton. This was disseminated via social media (specifically Instagram and Facebook), and via charities and community groups, for example those specialising in support for LGBTQIA+, BME and disabled people. The survey was disseminated to a total of 88 different charities, community groups, and other organisations/institutions. This survey was designed using JISC Online Surveys and was disseminated via an online link and QR code. It was 'live' (allowing for respondents to complete it) between September and December 2023.

The survey collated details regarding experiences of DA, asking participants what they think support needs for victims/survivors of DA are, together with questions regarding potential barriers to accessing support. It was completed by those who had and had not experienced DA, and those who had and had not utilised support services previously. The survey collected demographic information in relation to gender identity, sexual orientation, age, disability, ethnicity, and sexual orientation. This information was used to classify survey responses in line with the three groups where appropriate, and to ensure responses were representative of a broad variety of individuals. The survey included a mix of tick box and open-ended, free text answers and was confidential. All responses remain anonymous and where identifying information was provided (such as names or email addresses), these have been withheld from the commissioning organisations.

All survey questions apart from consent and confirmation of age were optional, which meant that not everyone answered every question. Where possible, this report indicates the ethnicity, gender identity/sexual orientation and disability status of the respondents, however, in some places that information was withheld by the person completing the survey or the research team where it might be considered a risk of compromising anonymity. Pseudonyms are given to all respondents quoted herein.

Focus Groups

The research intended to conduct four focus groups; one with practitioners providing support to victims/survivors of DA, and one each for representatives of the three minority groups. It was felt important to reflect practitioner perspectives on the needs of bespoke communities and identify good practice and/or areas of improvement.

During the course of the project, we contacted 30 organisations representing the minority groups and providers of DA support and a total of three individuals expressed an interest in participating in focus groups. Of those three, only two participants attended an arranged session in January 2024. Further promotion continued until the end of the data collection period however no other professionals were forthcoming in the timeframe. Both participants worked in the same local authority but in different roles; one ("Fay") as an IDVA[2] and the other ("Louise") in housing services.

Interviews

The research was designed to include a minimum of six semi-structured interviews for those with lived experiences; two interviews from each of the three groups (LGBTQIA+, BME, and disabled people) who had accessed DA services. We reached out to seven service users (1 LGBTQIA+ person, 4 BME people, and 2 disabled people) and two agreed to be interviewed (one BME and one disabled person who was also BME). Consequently, two online interviews (with "Maya" and "Rhea") were conducted via Zoom and the audio of each interview was recorded with the explicit permission of the interviewee. These have been transcribed and analysed using reflexive thematic analysis (see section below).

Data Analysis

The fieldwork consisted of a blend of both quantitative and qualitative data. Quantitative data is measurable data observed and obtained in checklist and multiple-choice forms. Quantitative data was obtained from the 'tick box' survey data. Qualitative data is rich, textual data that is drawn from conversations, interviews, and open-ended questions. Qualitative data was obtained from the free-text survey answers, the focus group and interview data. The combination of both types of data collection ensures the research addresses questions of both *what* is happening, and can provide summarised statistical information, and *why* people think so, including an investigation to the underlying meaning behind responses.

For the purposes of the report, we have included all data collected, but have also broken-down specific demographics for the participants of specific groups or who lived in Southampton where appropriate.

Quantitative Survey Analysis

Data cleaning was used to edit the raw survey data to identify any data points that could hamper the accuracy of the results (further detail in relation to this is available upon request). Descriptive analysis was undertaken to summarise the data, followed by inferential statistics to identify potential relationships between variables, with a specific focus on factors that might influence or indicate types of support desired (further information in relation to this is available upon request).

The majority of the questions were optional; hence respondents did not have to complete them all. Therefore, the data analysis is not a *whole case analysis* of each of the 317 respondents for every question, but the findings are presented with an 'n' (to represent number of respondents) where there is missing data (e.g. n=300 means 300 of the 317 respondents completed that question).

Focus Group, Interviews and Qualitative Survey Analysis

Thematic analysis was used to analyse the qualitative data. For the focus groups and interviews Reflexive Thematic Analysis was used (Braun & Clark, 2022). This involved extensive and reflective reading of the transcripts before inductive coding by the research team. Codes are the outputs identified in the data and were informed by the research questions, the research team's knowledge and expertise, and insights from the participants themselves. An example of a code would be 'having a voice': this indicates when the victim/survivor mentioned, insinuated or desired that they or others they know needed to be heard/listened to.

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[2] Independent Domestic Violence Advisor

Coding is therefore an open process of meaning making and interpretation of the data, and these codes were then analysed and compiled into overall themes. Themes are produced by groups of codes which have shared meaning around a central topic. For example, the code ‘having a voice’ was merged with other codes (such as ‘lack of knowledge’) into an overall theme of ‘support needs’. Coding and theme development for the interviews and focus group are included in Appendices A and B.

For the qualitative responses to the survey data, the research team compiled a codebook (or coding ‘template’) as a tool to assist in the coding, drawing on existing knowledge and informed by coding of the interviews and focus groups (Braun & Clarke, 2022; King, 2012). This enabled a more structured approach to coding and theme development and provided insight and symmetry through the coding process. Coding for the qualitative survey data is included in Appendix C.

Throughout the coding and thematic analysis process the research team worked collaboratively and rigorously. Theoretically, the research was conducted using a constructionism framework (meaning making from the data) and using pragmatism as the ontological approach which ensured methods aligned with the goals and purpose of the research.

Pseudonyms have been used throughout to maintain the anonymity of all those involved.

Research Findings

Survey Findings: Demographics

Area of residence

As this was a commissioned piece of research on behalf of Southampton City Council, it was of note that two-thirds (n=212) of survey respondents lived there (Appendix I). A list of all postcodes is in Appendix D.

Figure 2 shows that 317 people completed the survey, with an age range of 16 to 83 and a mean age of 35.

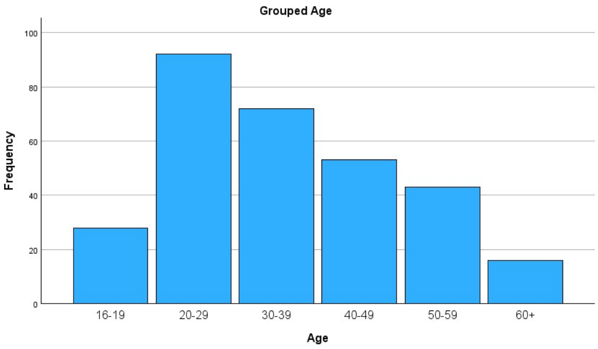

Figure 2 - Age Groups of all respondents (see Appendix I for breakdown by Southampton only)

Nationality

The majority of participants (n=216, 74.7%) described themselves as British, and a further 36 as English (n=252 combined, 87.2%), however there were also a wide range of nationalities from across the globe. Full tables of Ethnicities and Nationalities are in Appendices E and F.

Gender

Most respondents identified as female (n=245, 77.3%). A further 24 identified as male, 18 gave other gender identities, and 30 participants chose not to answer this question (see Table 2).

Gender	No. of Participants N=317	Percentage (%)
Female	245	77.3
Male	24	7.6
Transgender	4	1.3
Non-binary	9	2.8
Queer	3	0.9
Asexual	1	0.3
Other (nonbinary, transgender, transmasculine, and gender queer)	1	0.3
Did not answer	30	9.5

Table 2 - Gender of respondents (see Appendix I for breakdown by Southampton only)

Four people identified as Transgender, but the data only showed one Trans male (self-described), with the other three identified as 'Trans'. There is also the possibility that some Transgender people may have selected the gender they have transitioned to. Those who identified as LGBTQIA+, non-binary, queer, or self-identified as 'other' reported that they felt they belonged to the LGBTQIA+ community, with the exception of those who identified as Trans and asexual (1 response). This may have implications when marketing services to different individuals.

Sexual orientation

The majority of respondents (n=219, 69.1%) identified as 'heterosexual/heterosexual' (Table 3). Just under 20% of respondents identified as bisexual (n=62).

Sexual Orientation	No. of Participants N=317	Percentage (%)
Heterosexual / Heterosexual	219	69.1
Bisexual	62	19.6
Lesbian	7	2.2
Pansexual	6	1.9
Gay	5	1.6
Asexual	3	0.9
Other	3	0.9
Queer	2	0.6
Chose not to answer	10	3.2

Table 3 - Sexual Orientation of respondents (see Appendix I for breakdown by Southampton only)

For those participants who live in the Southampton area, all lesbian and pansexual respondents plus the majority of gay (n=3, 60%) and bisexual respondents (n=44, 71%) felt they belonged in the LGBTQIA+ community, the others did not. As highlighted above, this could have implications in marketing services; if service providers want to be inclusive, a focus on those who identify as members of the LGBTQIA+ community may incorporate the majority, but not all individuals.

Ethnicity: BME

As outlined in Table 4, 33 respondents (10%) identified as having an ethnic minority identity which fit within the 'BME' group, yet slightly more (11%) identified as being part of the 'BME' community. This could be explained by the fact that ethnicity for some participants was unclear, as they described themselves by their nationality, for example, "British", or some people who may not see themselves as being BME, but still may see themselves as part of that community. When looking at the Southampton area, 69.7% (n=23) of BME respondents felt belonging in the BME community as well as 12 (5.0%) of non-BME respondents. Again, this may be of note in marketing such services, in that the majority, but not all ethnic minorities may identify as part of a BME community in this area. *It should be noted that in the questionnaire the word BAME was used not BME.*

Simplified Ethnic Group	No. of participants (n=303)	Percentage (%)
Not BME	241	79.5
BME	33	10.9
Unclear	29	9.6

Table 4 - Ethnicity of respondents (see Appendix I for breakdown by Southampton only)

Disabled people

170 people (53.6%) answered yes to the question 'do you consider yourself a disabled person', yet only 30% identified as having a sense of belonging to the disability community. A summary is in Table 5 with a full breakdown of all impairment categories in Appendix G. The most cited disability was 'mental illness/nervous disorder' (n=147; 45% of total cases) with significant numbers with Autism and Mobility Impairments also apparent.

Disability	No. of Participants (n=170)	Percentage (%)
Mental Illness, Nervous Disorder	147	86.5
Mobility Impairment	48	28.2
Autism	47	27.6
Other (see Appendix G)	24	14.1
Specific Learning Difficulty	21	12.4
Deafness (Hearing Impairment)	15	8.8
Fibromyalgia	10	5.9
ADHD	9	5.3
Blindness (Visual Impairment)	6	3.5

Table 5 - Disabilities of respondents (see Appendix I for breakdown by Southampton only)

For those participants living in the Southampton area, only 55.3% of disabled respondents felt a sense of belonging to the disability community, suggesting a potential lack of disability organisations and services in the area.

Religion

The majority of respondents, 58.5% (n=176), stated they had no religion, with the second largest group, 30.2% (n=91) identifying as Christian. The data also included eight (2.7%) Pagan individuals, six (2%) Muslim individuals and a range of other religions shown at lower frequency such as Buddhism, Hindu, Sikh, other spiritualities.

In summary, as seen from the demographic information presented above, the survey included a representative number of respondents, of varying ages, ethnicities and religions, predominantly from the Southampton area. In addition, the respondents included representation from each of the target communities. As such it is viewed as representative of the target population. Elements of intersectionality were also seen, where individuals belonged to more than one group. For example, of the 170 disabled participants 5.3% identified as BME and 38.2% as LGBTQIA+. These findings, particularly that people may not identify with certain groups, or may belong to several, should be considered in terms of appropriate marketing when attempting to engage with specific groups.

What DA Services have participants accessed

Over two-thirds (69.7%) of respondents said they had accessed some sort of support from DA services, and 63% of these indicated that this was in relation to their own (not others') needs.

In relation to the target communities 68 (64%) LGBTQIA+, 27 (12.2%) BME and 125 disabled people (56.6%) had used DA services. Over half (n=164) of those who answered had accessed Yellow Door, and just under 20% had accessed Stop Domestic Abuse (n=62).

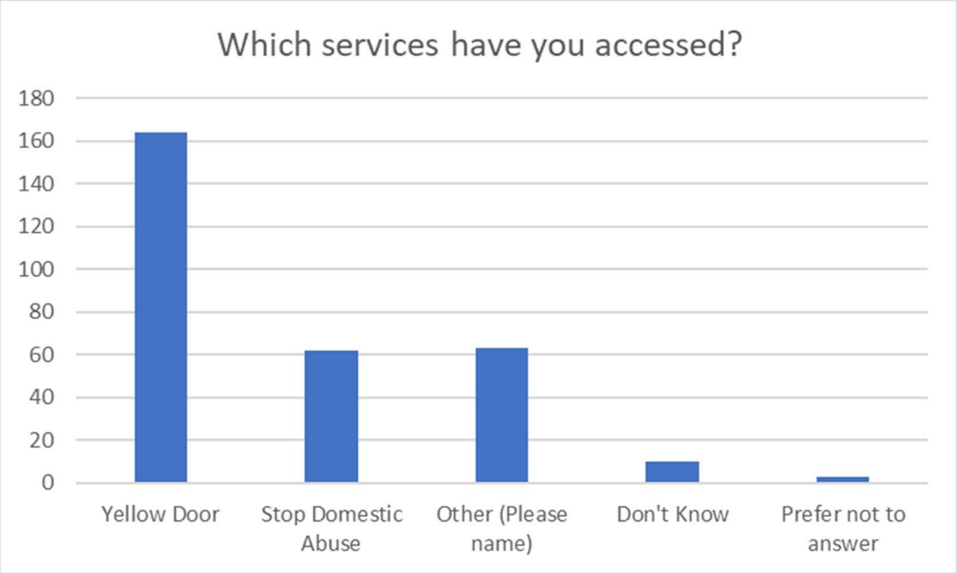

Figure 3 - Accessing Services

The range of services accessed these participants accessed are listed in Table 6 (with full details of other at Appendix H), showing that over half of participants were accessing counselling services; over 40% accessing mental health support; and over 34% with considerations such as how to leave their partner or seeking to report an offence.

Range of services	No. of Participants (n=317)	Percentage (%)
Counselling	163	51.4
Mental Health	130	41.0
How to remain safe	113	35.6
Advocacy	110	34.7
How to leave	64	20.2
Children	61	19.2
Legal Advice	59	18.6
Reporting an offence	57	18.0
Housing	45	14.2
Physical Harm	37	11.7
Finances	17	5.4
Other	6	1.2

Table 6 - Range of services accessed

In summary a wide range of services were accessed by a variety of individuals. The main services required were counselling and mental health support. We will now evaluate what those who had previously used services found useful hence support services should continue to further develop.

Evaluation of services – What worked well

Over two thirds of our respondents stated that the support they had received was at least partially useful, with one third stating it was very useful (Figure 3).

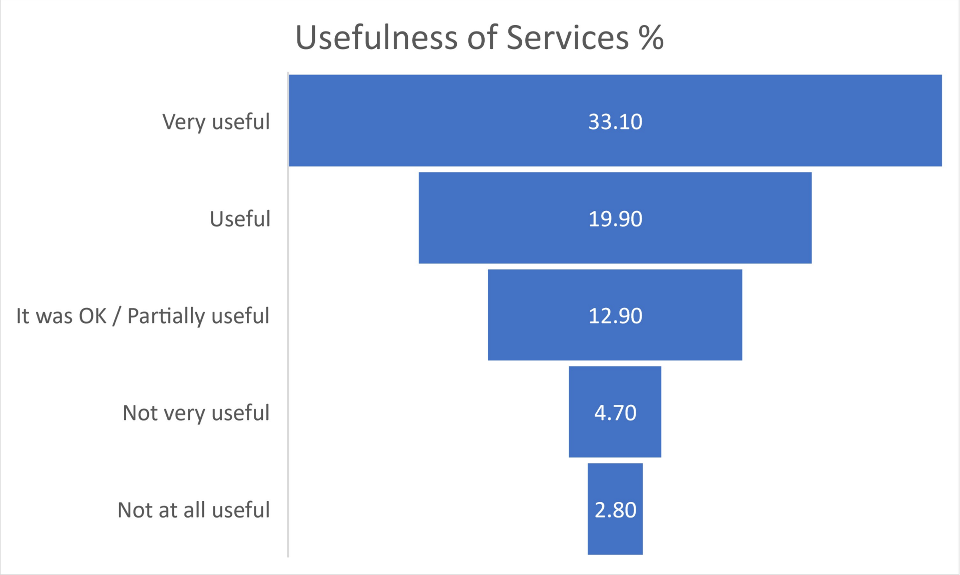

Figure 4 - Usefulness of Services

For those who had previously utilised support services, respondents were asked to complete free-text answers detailing how useful it was. There were many examples, however a selection of example quotations have been identified to highlight key (yet repeated) points made.

Respondents described many different types of support which were effective, including practical help such as having alarms fitted, legal support, advice regarding housing and gaining knowledge generally. As highlighted in Table 6, the importance of emotional support was key, in the form of encouragement, understanding and empathy which enhanced wellbeing, and participants noted that the help allowed them to feel more confident, safe, supported and sane:

> *"She helped me laugh and calm down and learn that what I was feeling was normal" (Mabel, White British, heterosexual, non-disabled)*

Specific services were also noted, including "pattern changing" and "trauma therapy", as well as how to recognise abuse and healthy boundaries, and a general acknowledgement that support was not just for themselves:

> *"The help offered to my daughter was amazing. She had counselling and has come a long way since" (Olivia, White British, heterosexual, disabled)*

Many positive responses were received in relation to staff, including the benefits of experience, being non-judgemental and feeling supported:

> *"I felt like she was on my side" (Anne, White British, heterosexual, non-disabled)*

The impact of support was significant, with numerous responses highlighting similar messages around the value of it, feelings of being validated, and that it was 'lifesaving', as exemplified by the following quotes:

> *"The support I accessed was amazing and I couldn't have asked for more" (Basma, British-Asian, heterosexual, non-disabled)*
>
> *"It made me feel like my emotions were valid and that I wasn't crazy" (Isla, White British, heterosexual, disabled)*
>
> *"Without their support I would not have been able to leave and I would likely not be alive" (Fleur, European)*
>
> *"DV support saved my life and I know that so please keep doing what you're doing and more, because there's people out there still going through it" (Angela, White British, lesbian, disabled)*

Evaluation for Yellow Door and Stop Domestic Abuse Services

> *"I had ongoing support from a domestic violence worker, two in fact - one from yellow door and one from stop domestic abuse, this was during COVID. I had weekly phone calls after being referred by the police. They were so supportive and made me understand that none of this was my fault. Always at the end of the phone if I needed them, (which I did). Greatly improved my understanding about gaslighting and narcissism. I probably wouldn't be here now without these such kind people"*
>
> Ava: White British, straight, non-disabled

For those respondents who had utilised the services of Yellow Door (n=164), more than half said the service they received was helpful, with 31.7% (n=52) scoring 'very useful' and a further 23.3% (n=38) scoring the service 'useful'. Only 7 respondents (4.3%) ticked that they did not find the service to be of any use. Again, free-text comments reflected this such as *"Yellow door made me feel safe and heard" (Aadhya, Indian-Asian, heterosexual, non-disabled)*

Of those who had used Stop Domestic Abuse (n=62), scores were similar with around two-fifths (40.3% n=25) scoring the service they received as 'very useful' and 17.7% (n=11) as 'useful'. Only one person scored the service as not at all useful. Comments included "*Stop Domestic abuse listened and supported and were accessible from the start" (Penny, White British, heterosexual, disabled).*

In summary, the majority of those who have previously used services found them useful in terms of both emotional support and practical help. In the main, the services provided by Yellow Door and Stop Domestic Abuse were rated very positively.

Evaluation of services – Secondary Victimisation: What could be improved

As well as positive experiences, some respondents also outlined a perceived lack of support which they described as being a form of re-victimisation by agencies, services and individuals they initially anticipated would support them.

Evidence of feeling let down by services was apparent:

> *"I was told by NHS officially: The abuse is too vile for them to handle. Or get over it and get on with it" (Maria, Black British, heterosexual, non-disabled)*

> *"unable to provide me with housing help or much useful information. I ended up becoming homeless" (Eva, Polish, heterosexual, disabled)*

> *"I was not listened to despite many neighbours etc reporting things. I was asked in front of my abuser every time to talk about what was happening" (Francis, White British, heterosexual, non-disabled)*

Being repeatedly signposted elsewhere was mentioned by several participants and also noted as a barrier to accessing services (see 'barriers' section below). The impact upon victims/survivors was significant, with some respondents wishing they had not contacted services, who made situations worse.

> *"I got passed around, had to retell different people my story over again in a bid to get help, and it's embarrassing only to then be told you don't fit the right box. I have seriously struggled to get the help I need" (Violet, White British, heterosexual, non-disabled)*

> *"I was moved from Wales to Southampton, 3 years later I am still in temporary housing, in debt caused by abuser while in a refuge! I have had 0 support since leaving, and I sometimes wonder if it would have been easier to stay" (Claudia, White British, heterosexual, non-disabled)*

This was acutely felt by participants of particular communities or for those with individual needs, for example:

> *"I've been thrown around in the help system because i have too many traumas… I just get pushed around in the system" (May, White British, bisexual, non-disabled)*

In some instances it was the nature of the advice and protection which appeared inadequate:

> *"it didn't feel like it gave me really any protection from him and harassment" (Jemma, White British, heterosexual, disabled)*

Whilst some of these concerns are beyond the remit of charitable support services, they link directly with the needs of victims/survivors and highlight how they feel services could be improved or where additional support in navigating systems would be of assistance to them. This will be further explored in 'support needs' below. However, continuing the evaluation for potential improvements to services, many respondents highlighted potential barriers to accessing support services.

Barriers to accessing support services

Just over half (n=160, 50.5%) of the respondents stated that they experienced barriers of some kind, which reduced their ability to access help and support. There were a range of barriers presented (see Table 7). The most frequently stated were embarrassment or shame, closely followed by not recognising the abuse and fear of what might happen, or of not being believed.

Barriers to accessing support	No. of Responses (n=160)	Percentage (%) *(rounded)*
Embarrassment or shame	109	68
Not recognising	107	67
Fear of what might happen	105	66
Fear of not being believed	101	63
Denial	90	56
Not a big deal	70	44
Hope things will change	64	40
Worry about information sharing	63	39
Love for abuser	52	33
Loyalty for abuser	50	31
Access	50	31
Worry about losing access to children	49	31
Worry about finances	46	29
Worry about losing friends and family	46	29
Worry about housing	41	26
Other	16	10

Table 7 - Barriers to accessing support (see Appendix I for breakdown by Southampton only)

In relation to specific communities, the findings were largely similar. However, people who identified as BME scored higher than average in some areas, such as fear of what might happen to them, denial and the hope that things would change. Additionally, 'loyalty to the abuser' was much higher for BME respondents and for the categories on housing and finance the response for the BME group was also higher.

For disabled people, the highest scoring reported barrier was fear of not being believed, as it was for the LGBTQIA+ community. Embarrassment or shame was also high for the LGBTQIA+ group as was not recognising the abuse.

Free-text survey answers also highlighted the emotional barriers faced by individuals in accessing help. Similar themes of shame and self-blame were apparent:

> *"I thought it was my fault and that I just needed to try harder" (Nancy, Mixed British, heterosexual, non-disabled)*
>
> *"I might be making a big deal and bringing shame" (Faiza, British Asian, heterosexual, non-disabled)*

These feelings were often related to a lack of recognition of abuse, or being in denial:

> *"I did not recognise it as abuse for a long time. When I did it hit me like a train and the flood of shame, fear and embarrassment were very intense" (Basma, British-Asian, heterosexual, non-disabled)*

> *"I always believed it will not happen to me" (Mei, British Chinese, heterosexual, non-disabled)*

> *"I did not recognise myself as a victim as I was not cowering in corners or being hit (well not regularly)" (Amelia, White British, heterosexual, non-disabled)*

There was a persistent fear of what may happen to respondents:

> *"I was terrified my abuser would find out I was getting help and therefore unsure if he would get worse" (Sienna, White British, heterosexual, disabled)*

> *"My abuser was actively looking for me and he said things such as he knows where I am who I'm talking to" (Isabel, White British, heterosexual, disabled)*

Many also discussed not being believed, which had several facets including fearing what others would think, the abuser being seen as convincing, and the response of professionals:

> *"I was scared on what people would think and that no one would believe me" (Ivy, White British, heterosexual, disabled)*

> *"My abuser was considered everybody's friend and a great dad. I was presented as the 'difficult' one" (Ella, White British, bisexual, disabled)*

> *"Was scared I wouldn't be believed as the police dropped my case very quickly" (Miriam, White British, bisexual, disabled)*

As can be seen, the views of professionals and other people can be worsened by appearances; for example, if criminal cases are dropped, it may appear police did not believe the victim/survivor; of if abusers portray themselves as charming, it may appear the victim/survivor is to blame. This also reflects elements of 'gaslighting' with some respondents being driven by the reactions of their abusers;

> *"the abuser makes you think you have mental probs" (Dawn, White British, heterosexual, non-disabled)*

For some poor health was used to further manipulate

> *"my ex would use his health conditions to imply that I was lying" (Lily, White British, heterosexual, disabled)*

> *"for many years my ex was able to use my diagnoses against me with [the] authorities… everything was justifiable on the grounds of concern for my mental health or parenting" (Freya, White British, heterosexual, disabled)*

Added to this, many lacked the confidence to seek help, citing fears of "wasting people's time" (Isla, White British, heterosexual, disabled). This layering of experiences, from lack of self-belief, lack of recognition of their abuse (compounded by gaslighting), fear of reprisals from their abusers or not being believed has a significant impact on women's abilities to seek help.

In addition to these personal reasons, others were worried about children or finances, as these examples show:

> *"the fear of losing the children was a big problem and stopped me from telling social services the truth" (Sophia, White British, heterosexual, disabled)*

> *"I was worried what would happen to the children - would social services take them from me if they knew what was going on? What would happen to me? I couldn't afford to leave my ex….*

> *Where would I go? The children were being manipulated into believing I was making things up and I wasn't prepared to leave them where this misinformation could continue without me standing up for myself" (Elsie, White British, heterosexual, non-disabled)*

The last quotation highlights the complex web of considerations faced by victims/survivors, particularly when children are involved and the effect it may have on them. As noted here and in the quotes in this report, victims/survivors may not get the help they need as they are loyal to the people they love, or are protecting others, including their abuser/s, sometimes believing things may change.

> *"I was in a couple different domestic abuse situations. One were my parents, who I cared for, didn't want them to get in trouble… Another one was with my ex-partner who I loved deeply and wished he would change and sort it out, I was trying to help him get better"* Rosie: White British, straight, disabled

Some were isolated and had other practical considerations such as not wanting or being unable to leave, or being unable *"to get out alone and unwatched by abuser" (Maisie, White British, heterosexual, disabled).*

These may have been exacerbated by bespoke difficulties due to cultural expectations and/or migrant status. Such significant, intersectional barriers highlight the need for bespoke services for minority groups:

> *"I hesitated to admit or seek support as I'm an Asian so I had a lot to lose in society and community culture played a big part. I was worried about shame and stigma" (Amala, British Bangladeshi, heterosexual, non-disabled)*
>
> *"As an immigrant I could not report early because I could not speak well, he was in control of everything" (Beatriz, Chilean, heterosexual, non-disabled)*

For disabled respondents, additionally, accessibility and carer responsibilities being delivered by their abusers were also significant barriers to accessing support:

> *"my needs were too complex (I'm autistic)" (Grace, English, 'other' gender, disabled)*
>
> *"it was hard to get there, being a wheelchair user" (Evie, White British, heterosexual, disabled)*
>
> *"I struggle with physical disabilities and with my partner I relied on him for support, physically, mentally and financially. I was terrified of being on my own and being stuck… it was terrifying" (Rosie, White British, heterosexual, disabled)*

As well as emotional, personal and practical barriers, respondents also highlighted service level or organisational barriers. The first of these focussed upon not knowing what services are out there for them. When asked how much they knew about DA support services, responses can be categorised into three main groups: Those with no knowledge of services *until* they had experienced or witnessed abuse; those with limited or some knowledge; those with extensive knowledge of support services (often as a result of a profession or career). Many describe knowing there is "support for domestic abuse" but not exactly *what* that support entailed. Some were able to source areas of support through TV and media campaigns, through contact with GP, education services, Police and other agencies. Again this has implications for where and how to promote help and support services within the community.

Many of the participants spoke of a desire for more targeted and varied promotion of what services are available and where. These included raising awareness of what DA includes, beyond stereotypical conceptions of physical violence, and promotions advertised in educational settings, healthcare settings, online, posters and TV, and in different languages. A lack of knowledge regarding services was often cited:

> *I didn't know where to go or who to talk to (Olivia, White British, heterosexual, disabled)*
>
> *I moved over 200 miles to get away and so didn't know anything about services in the new area (Nicky, White British, heterosexual, disabled)*

Some made suggestions for organisational practice in relation to access, focussing on the need for a coordinated approach with a central hub:

> *"Too many satellite agencies and resources that half don't know about the others so how is a victim meant to know about them and which is the best one to turn to? Needs a nationally recognised and well publicised umbrella "face" so that any person experiencing abuse knows exactly where to turn to first and then perhaps through an online triage process are filtered through to the different organisations local to them who can help and a handholding online "advocate" appointed" (Phoebe, White English, heterosexual, non-disabled)*

Another organisational barrier related to difficulties in accessing support services. Numerous respondents highlighted long wait times (between 2-3 years), stating they wished they could have accessed services sooner, expressing a strong desire for improvements in this area. Delays between referral and gaining support resulted in severe consequences for victims/survivors including considering taking the perpetrator back and suicidal thoughts:

> *"I waited for so long to be contacted... in the end I had to find my own private counsellor as I could barely cope with living anymore" (Angelina, White Portuguese, heterosexual, non-disabled)*
>
> *"It would have been useful to get the support earlier - it came several months after the incident and I had a lot of low days while waiting, including thinking of taking the abuser back" (Nihal, Sri Lankan, heterosexual, non-disabled)*

Respondents also wanted sessions more frequently and to be able to utilise them for longer to help deal with ongoing trauma and *"post recovery support" (Ella, White British, bisexual, disabled*). Other examples include:

> *"I wish it was more than 1 time every 2 weeks. At least once a week would of helped more" (Isabel, White British, heterosexual, disabled)*
>
> *"Sessions need to be much longer… 12 or 14 or 16 most definitely are not… enough" (Enid, White British, heterosexual, disabled)*

One participant describes a desire for longer support but felt:

> *"I shouldn't disturb the IDVA case worker after the trial was done because she had to work with a lot of women who were actively in a situation or seeking safety" (Nihal, Sri Lankan, heterosexual, non-disabled).*

This form of self-sacrifice was witnessed elsewhere by participants who spoke about not wanting to be a burden, being conscious there is not enough supply to meet demand, but this obviously puts individuals at risk of further harm if they do not seek and get access to help when required.

A lack of follow-up support was also evidenced, with some respondents describing a ‘drop off’ at the end of their support, and the emotional impact this could have. Here again we see the risk of women returning to their abusers or to another toxic relationship because of the lack of long-term support;

> *“all support thrown at you at the beginning can almost feel overwhelming, but after a few months, it suddenly disappears and you are left alone in the ruins of your life” (Evelyn, White British, bisexual, disabled)*
>
> *“there was no follow up help even though they said there would be” (Becca, White British, heterosexual, non-disabled)*
>
> *“At the end of the session that I attended I was not given any instructions on what to do next” (Helvi, African, lesbian, non-disabled)*

“During that time I wanted to end my life… if the service isn’t helping people correctly in general, it seems it needs on that first”

Violet: White British, straight, disabled

One respondent suggested a solution could be a *“care plan after-checking in programme to prevent them returning to their abuser” (Charlotte, White British, bisexual, disabled).*

In addition, there were other comments related to availability of access in their locality and at relevant times, as services are not always available outside of normal ‘working hours’ when abuse is more likely to happen:

> *“limited access to resources, they weren’t close enough or easy enough to find” (Orla, British-Irish, bisexual, disabled)*
>
> *“either I couldn’t physically get there, or the provision did not extend to the Isle of Wight (despite being part of Hampshire). Also, alternatives were self-funded support which was too costly” (Evelyn, White British, bisexual, disabled)*

As highlighted above, a repeated message was that respondents felt they were directed from one service to another:

> *“Too many fragmented services and charities endlessly being sent from pillar to post. I never feel like you’re moving anywhere” (Jemma, White British, heterosexual, disabled)*
>
> *“I feel like I am walking in a maze” (Valerie, White British, heterosexual, disabled)*

However, participants recognised it was not the fault of support services, but down to a lack of resources:

> *“Too long waiting list because it's severely underfunded” (Rosemary, White British, heterosexual, non-disabled)*
>
> *“More funding to allow more access to support and reducing waiting times” (Sienna, White British, heterosexual, disabled)*

In summary there appear to be significant barriers hindering victims/survivors getting support. These may be more acute for certain individuals or groups for a variety of reasons. Whilst personal and emotional barriers may be difficult to address; organisational barriers, such as making services accessible at the point they are required and continuing to offer support for as long as victims/survivors need, requires adequate funding and resource. These are linked to more general considerations – the support needs of clients.

> *"Don't use long words, or words shortened like DA … people in a distressed state struggle to process things anyway without jargon involved. Make sure things are set up in a simple and clear way, with encouragement at every step of the way "well done you found your way to this site that's a great first step" etc etc… it builds trust"*
>
> Iris: White British, straight, non-disabled

Support needs – General

In the light of the aforementioned considerations it was also important to understand what users want from service providers going forward – i.e. identifying their needs. There are a variety of services highlighted in Table 8, and, similar to what services were used, the most frequently reported services requested were access to mental health and counselling support, followed by advice regarding how to remain safe, and advocacy.

Required services	No. Of Participants n=317	Percentage
Medical Support: Mental Health	217	68.5
Counselling	214	67.5
How to remain safe	211	66.6
Advocacy	201	63.4
How to leave a partner/abuser	197	62.1
Reporting an offence	192	60.6
Legal advice	191	60.3
Housing/access to refuge	188	59.3
Medical Support: Physical Harm	186	58.6
Finances/Money	181	57.1
Your children/dependents	180	56.8
Other	16	5.0

Table 8 - What services should be available?

In free-text answers, respondents expressed a strong desire for greater service provision for DA support. This included suggestions for more outdoor activities, more local projects and support groups, more online resources, include video call access, a 24/7 support line, and a 'friendship' service to support those not yet ready to leave their relationships. Additionally, respondents would like more 1-1 sessions, particularly more counselling provision. Furthermore, there was a desire by some for more accessible services, and for assessments to be made 'easier' and less 'complex'.

Comments included:

> *"An appointed advocate for each victim who will ensure that the victim has been contacted, is being given the support they need, help with referring themselves etc would be hugely, hugely beneficial – someone who can take that immense weight off our shoulders when we are already overwhelmed by just trying to survive daily life" (Phoebe, White English, heterosexual, non-disabled)*

> *"There needs to be an organised step by step system of provision… and it all needs to be mapped out and available for the person to move through at their own pace and as they choose" (Sophia, White British, heterosexual, disabled)*

The demand for refuge and emergency accommodation was high, with comments including

> *"more safe spaces for victims to leave at short notice when it's safe for them" (Maisie, White British, heterosexual, disabled)*

In addition to other more basic needs, such as the need for confidentiality, several respondents highlighted the need to feel supported and be heard. There were a mix of experiences in relation to this with some comments about being minimised, others highlighting support workers gave them a voice:

> *"People don't want to hear about it. It is beyond belief for most people, including regular counsellors" (Sophia, White British, heterosexual, disabled)*

> *"The support workers… were the only ones who listened to me, believed me" (Maria, Black British, heterosexual, non-disabled)*

Overwhelmingly from respondents answering what support they would have liked but did not receive, again counselling services and support for mental health were emphasised. Specific needs were broad but centred around requiring therapy, mental health support, help for children, financial, housing and legal advice such as that outlined below:

> *"Support challenging the decision to take No Further Action. Support coming to terms with that and what that meant" (Poppy, White British, non-binary, disabled)*

> *"insufficient support in terms of where to go, suitable housing" (Grace, White English, 'other', disabled)*

This included recognition of intersectionality in experiences and needs:

> *"I was going through an eating disorder at the time so I wasn't given counselling until my physical health was sorted" (Cathy, White British, heterosexual, non-disabled)*

The methods and delivery of support were also discussed, with respondents stating the benefits of being able to connect remotely by means suitable for them, as these examples show:

> *"I did mine online video call I was in the comfort of my home but could see the person I was talking to so could make a connection with her" (Florence, White British, heterosexual, disabled)*

> *"I liked that I could communicate over the phone via calls and texts as I didn't always feel like talking or showing my face" (Miriam, White British, bisexual, disabled)*

Yet others outlined they would benefit from meetings in their local area:

> *"Opportunities to be able to meet with other women with similar experiences" (Josie, British, heterosexual, disabled)*

> *"I feel the group has its benefits but I really needed 1-2-1 guidance" (Violet, White British, heterosexual, non-disabled)*

The need for support tailored to individual needs was therefore seen as important in putting clients at ease, as one person put it:

> *"they offered to find ways for me to be more comfortable and safe through doing something I love IE. drawing or listening to background music while we talked" (Isabel, White British, heterosexual, disabled)*

In summary, there are patterns which can be identified as broader, more general needs of victims/survivors, but also there are individual differences, such as, for example, preferences for types help and forms of support provision. As such, individualised needs should be taken into account and accommodated wherever possible. These can be even more acute when bespoke needs of specific communities are considered, which we will address in the following section.

Support needs – Bespoke: BME

80% of the survey respondents who identified as BME, believed BME individuals have specific needs for support, as did 64.2% of individuals who had previously used DA support services. In the free-text comments BME women described experiencing stigma and blame for leaving relationships, and pressures to remain with their abuser. One woman spoke of being moved to a refuge in a predominantly 'White' area which left her feeling 'out of place' from her community.

> *"Perhaps being given the opportunity to speak to someone from my own cultural background who could help support me as I lost every member of my family in the process of fleeing and have been culturally ostracised by my community"*
>
> Jasminder: British Indian, disabled

Respondents identified why and how migrant and BME communities might need additional support, such as how different cultural expectations can mean individuals might be less likely to report or to seek help, or it might be difficult to recognise they need help (a small number recognised the risks of 'honour' based abuse).

> *"language barriers and cultural differences may mean people are unable to access services, are unaware of they are more likely to put up with or minimise the abuse" (Ruby, White British, heterosexual, non-disabled)*

> *"Some cultures make the abuse that victims go through normal and forced to be accepted" (May, White British, bisexual, non-disabled)*

Support needs – Bespoke: Disability

Disabled (57.5%) and non-disabled participants (42.5%), as well as service users (73.3%) and those who had not previously used services (85%), felt disabled people have specific help and support needs in terms of DA services.

> *"I'm suffering severed anxiety, and scared… I cannot go on the bus to an organisation as it would make me even worse"*
>
> Valerie: White British, straight, disabled

Free-text comments varied from ensuring appropriate communication aids were used, production of easy read versions of resources, to accessible access and, relatedly, to challenges in identifying suitable accommodation. Significant numbers of respondents reported experiences of increased difficulty in accessing services due to a variety of mental and/or physical health conditions.

> *"Those with disabilities may find it difficult to leave an abuser and tailored advance to make things safer for them would be helpful" (Alice, White British, heterosexual, disabled)*
>
> *"mental illness can make it difficult to advocate, and make it look like the victim is the perpetrator when police and people are underinformed about what mental illness and trauma look like" (Grace, White English, 'other', disabled)*
>
> *"The main thing I think would help is autism friendly shelter. By which I mean quiet, self contained, private places people can stay until genuinely suitable housing is found for them. Autistic people can't be expected to live in ordinary shelters, I've done it and while I've appreciated them existing it's such a strain on an already overwhelmed sensory system" (Ella, White British, bisexual, disabled)*

Support Needs - Bespoke: LGBTQIA+

Individuals of all types of sexual orientation believed that LGBTQIA+ individuals have specific support needs. However, some felt that all victims/survivors should have the same support, and sexual orientation or gender identity should not distinguish them:

> *"These groups ask to be treated the same so why should they not be treated the same and given extra, it's not an illness" (Vincent, White British, heterosexual male, disabled)*
>
> *"If we start focusing on special groups to get help, the general non-minority people will not get the support required as they will not be specific enough… efforts should be spent on dealing with the abuse no matter your sexuality" (Violet, White British, heterosexual, non-disabled)*

As such the concerns appear to be situated around a lack of support generally. Nevertheless the majority of respondents advocated for specific support in recognition of specific challenges such groups face, including discrimination, increased isolation, or relationship dynamics which may make the abuse harder to identify and to seek help. Examples include:

> *"they would have had a different experience of abuse as it is a different kind of relationship and there are other factors to consider" (Ellie, British French, bisexual, non-disabled)*

> *"I think in same sex relationships it can be quite difficult as it's not gendered abuse so that might mean it is harder to get help. Additionally this might affect traditional gender roles / identity such as male on male violence" (Freya, White British, heterosexual, disabled)*
>
> *"Services need to be tailored to the LGBTQIA+ community to show help is for everyone and fully inclusive" (Ruby, White British, heterosexual, non-disabled)*

An argument for user-led services was encouraged:

> *"She [service provider] was also part of the LGBTQIA community and I think her lived experience allowed a deeper level of understanding" (Angela, White British, lesbian, disabled)*

This need for bespoke services, with individuals having experienced, or at least with a good working knowledge of experiences certain groups may encounter, is highlighted repeatedly throughout these findings. It seems that bespoke knowledge reduces the need for the victim/survivor to have to explain everything about their situation, hence reducing their distress, and enhancing their feeling of being fully understood and supported. A Muslim woman not having to explain her additional potential difficulties in getting a divorce; an autistic woman being understood when she explains the difficulties she may face being placed in a noisy, busy refuge in a new location; or a physically disabled woman wholly reliant on her abuser for physical care facing additional practical difficulties. Such circumstances may add an additional layer to the trauma caused, and a full understanding of such complex issues would help the victim/survivor in their journey.

Whilst beyond the explicit remit of this report, during our analysis there were two groups (male victims/survivors; transgender individuals) who also appeared to have specific bespoke needs and as such these will briefly be considered in turn.

Male victims/survivors

There were 24 male victims/survivors[3] (age 16-83) who completed this survey, 19 lived within Southampton. Their data have been separated to ascertain if there are any specific findings in relation to this group. Half the male respondents did not answer the question on having knowledge about support services, but ten of the men had accessed services for support.

Interestingly, half the men also chose not to answer the question about the gender of their abuser, but of those that did, two selected female, seven selected male, and one selected 'other gender identity'. 18 of the men were heterosexual/heterosexual, with four identifying as bisexual and two were gay.

Nine men stated they sought help for themselves and one for their parent (their mother), with half stating it was useful or very useful and half stating partially or not very useful. Seven of the men had accessed Yellow Door, and two Stop Domestic Abuse. One of the participants felt the support did not meet their needs:

> *"I feel the support offered was designed by neuro-typical people for neuro-typical. I came away feeling more hopeless than when I started" (Ryan, 43, English, heterosexual, disabled)*

Feeling this was because he was "a man". Another felt the conversations were "*fruitless*" *(Neil, 19, British, White, gay)*, and another said:

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[3] Due to the small sample size, actual number of respondents will be reported here, rather than as percentages.

> *“Absolutely no help whatsoever, useless services, lacked any sort of empathy or understanding” (Thomas, 24, Italian, White, bisexual, disabled)*

However, others had different perspectives:

> *“They had a lot of good advice and I felt supported through the service. I was told how to keep myself safe and how to get a non-molestation order” (Rajesh, 20, British, South African, Indian, bisexual, disabled)*

> *“It provided a safe space to have a balanced discussion” (Rick, 53, British, White, heterosexual).*

When it came to barriers to accessing support, one participant wrote:

> *“I always felt there was someone in a worse position than me, so I avoided reaching out” (Barnaby, 22, British, White, bisexual, disabled)*

Such themes are reflective of those seen in the female respondents – a mix of positive support and things which could be improved, particularly for certain groups; and consideration of barriers, including self-sacrifice, thinking others were more deserving.

Other comments reflected bespoke difficulties, for example surrounding the ideas that society has around the gendered nature of abuse and a lack of knowledge in society and professionals:

> *“I am a 5'10'' Stocky male who suffered DV at the hands of a petite size 6 women, I was brought up never to raise a hand to a female at whatever cost, the law took one look at me and saw a perp not a victim” (Vincent, 62, British, White, heterosexual, disabled)*

When it came to support that they would have liked, in the main these reflected the findings of women - for more funding, resources, knowledge of what constitutes abuse, practical and psychosocial support, but one talked of the need for having the same level of support that women received:

> *“I really had to research to find support services for men... I found there was a lot more support for women out there than men who have experienced the same” (Matt, 37, British, white, heterosexual)*

In terms of bespoke needs for BME people, male respondents also noted the need to understand cultural differences/issues, the need for translation services, and understanding that people who do not have permanent residencies may have to leave the UK.

For disabled people, male respondents felt there should be bespoke needs to understand specific vulnerabilities that they might have in terms of coercive control, reliance on the abuser and bespoke needs in communication:

> *“As an autistic person I already struggle with open ended questions and 'speaking freely'. The only person I feel I have ever made 'progress' with just seemed to ask questions I was able to answer and would prompt further answers” (Ryan, 45, English, heterosexual, disabled)*

In terms of bespoke needs for people who identified as LGBTQIA+, male participants noted they needed the same support as others, however one participant felt

> *“fear and isolation can be particularly high. Having someone of the same identity or a similar identity would help make queer people feel more comfortable.” (Rajesh, 20, British, South African, Indian, bisexual, disabled)*

It was notable that one participant noted that all three groups should be treated in the same ways as everyone else, stating that:

> *"why are you asking such a question when all they ask is to be treated equal? All you are doing is separating these groups from the people they are asking to be equal to which in turn goes to adding resentment to the very groups you are saying need extra help" (Vincent, 62, British, White, heterosexual, disabled)*

It seems therefore that many of the experiences of men as victims/survivors are similar to those of women, yet there are also individual differences in views, and some potentially bespoke issues they encounter alongside other 'minority' groups in this field.

Trans men and Trans women

Although only a small number of participants identified as transgender, the issue of services for trans people was discussed. There were concerns about the suitability of provision for trans men and women, reflecting wider cultural debates on the issue.

Thea and Bella both expressed concerns about women's safety in support services. Thea (White British, bisexual, disabled) was particularly concerned about trans *women* in women only services, adding "*Let trans people have their own services, but not at the cost of women... Having women's groups with trans women means that women don't feel safe*". Bella (White British, heterosexual, disabled) also suggests "*there should be male/female and LGBTQIA+ support groups*", though acknowledges the impact on service provision and limited resources. This relates to a comment by Jasminder, who spoke of having a trans person in a refuge with her, who "*had a male presence about them*" which produced feelings of fear for some, though Jasminder recognised the complexity of the issue, adding: "*I don't know what the best action would have been for anyone*" (British Indian, heterosexual, disabled).

One respondent, who identified as a trans man, wrote:

> *"Refuge offer was not suitable for me as a trans person. I am non-binary and choose to present as a man, but was offered a women's refuge place... There also needs to be more refuges and more options for trans people to go [to]. offering a trans man a place is a women's refuge is an insult and could be dangerous for that trans man" (Blake, White British, disabled)*

Blake expressed a strong desire for services for trans individuals to have input from trans and other LGBTQIA+ charities to ensure they are carefully provided for.

These comments suggest that provision of services needs to be carefully considered and involve representation from all communities involved. Women's fear of male "physicality" impacts upon their sense of safety within DA services. Likewise, trans people's sense of safety and vulnerability are at risk in the 'wrong' environment.

In summary there were several key findings from the survey data in relation to what services people found useful, some detail of how they feel improvements could be made, and comment regarding bespoke needs for certain groups. These findings will be further explored with practitioners working in the field who undertook a focus group.

Focus Group Findings

What services are currently doing well?

There is an acknowledgement, from those working within the organisation, that the local authority's practice of addressing DA through housing provision is exemplary. Both participants spoke of efforts made to secure and support service users in their own homes, to work with other agencies collaboratively, and to address perpetrator behaviour (through criminal justice routes and intervention programmes), which they describe as a material shift in how perpetrators are dealt with:

> *"I think one of the shifts that has happened and I don't know how much this is not just in Southampton… is that this is our priority, to attempt as much as possible to keep people in their own home, that managing a move is not necessarily the best option" (Fay)*

They attributed their success to their Domestic Abuse Housing Alliance (DAHA) accreditation which has enabled them to take a more holistic, view across services, as well as the independence of Southampton in that it owns its own housing stock (but see below for supply problems). Part of the success of the DAHA programme is it looks at how housing services interact with other provisions, such as domestic abuse services, which Louise says is driven by a desire "*to make the offer of accommodation as flexible as possible*".

Both participants cited examples of local organisations that provide extensive and tailored support - Breakout Youth, No Limits, Yellow Door, Stop Domestic Abuse, the Clear Project, plus educator advocates, and other outreach support and 'by and for services' (see below). Other extended areas of support come from family networks and close communities (something particularly highlighted in Southampton in terms of its socio-spatial design), as well as religious groups.

What could be improved by services

A number of barriers were highlighted in the delivery of DA services. These include lack of housing stock, high demand for services, and a lack of 'by and for' services (provision provided by those with lived experiences, either in relation to DA, or in terms of identity characteristics).

One participant made analogy to the national picture of public services funding as a "leaky roof", when cases come in

> *"we are putting a bucket underneath the hole and we're catching as many as we can and we're trying to stop the place from flooding" (Louise)*

Not everyone gets caught in the 'bucket' and not everyone's needs "fit within that bucket" even when they are caught.

The issue of unsustainable demand for housing is a significant concern, one participant describing how, at the time of focus group, there were 184 families in temporary housing in Southampton, with another 120 families waiting, and their having to use hotel accommodation "to meet the need" (Louise). They acknowledged this national problem of resource was replicated locally, but nevertheless should be a priority:

> *"if I could wave a magic wand on how we could be better... we have more access to accommodation, interim accommodation, emergency refuge accommodation… dispersed accommodation... I think that would really level us up" (Louise)*

They also described challenges of working with complex cases, stating that the more complex the case it's likely the lower down the hierarchy of support service users become. Louise stated:

> *"having access to that accommodation when there are added complexities or intersectionality aspects that we need to be aware of is already tricky"*

Fay described a case involving a disabled women who was a victim of DA and, having spent a long time having her property adapted for her mobility issues, was adamant she was not going to move. The change in practice to support DA victims/survivors in their own home, particularly given there is only one refuge in Southampton which has a disabled adapted room, was therefore welcome.

Conversely, there was a challenge in those cases which are not perceived as sufficiently high risk which means services are not provided automatically, as (because of demand) only those cases which are high risk result in some services,

> *"if you know it's medium risk so they're not getting an IDVA... if they're not a young person, then I would say there really isn't much [support]" (Fay)*

Additionally, a case which is not graded as high risk means the victim-survivor needs to consent to support, which in many cases they do not so service providers cannot intervene.

Furthermore, there were barriers in longer-term support for victims/survivors to ensure they have strategies in place to avoid future harm due to

> *"extremely limited support around recovering from domestic abuse" (Fay)*

such as the longstanding trauma, vulnerability and negative mental and physical health impacts.

Bespoke communities specific service needs

There was a clear recognition of the complex, intersectional nature of the lived experiences of victims/survivors of domestic abuse. This included specific needs for BME communities in terms of language and translation services, immigration status and no recourse to public funds. For example,

> *"just trying to find an interpreter can take a very long time and then that has a real impact on the victim. It has a real impact on what you're attempting to do" (Louise)*

Disabled women faced unique challenges in terms of appropriate housing support and accessible refuge spaces.

Despite support being available in some areas, participants highlighted the intersectional nature of LGBTQIA+ provision, in that younger members of the community had greater support access, something which is lacking in the older population,

> *"if you look at the LGBTQ+ community... in terms of what's out there in the community, if it's not for young people, my understanding is there really isn't much out there" (Fay)*

Hence, the complexity of needs of some service users puts them at multiple, in some cases distinct, disadvantage when it comes to accessing support and/or accommodation. By and for services, where provision is offered from someone within the community, was highlighted as best practice

> *"acknowledging that people with the same lived experience are able to offer a better, more enhanced or better understanding level of support" (Louise)*

However, it was acknowledged as not always available to Southampton residents due to population demographics, consequently "their needs are not being met" (Louise).

In summary the focus group analysis echoes key findings from the survey. High demand, yet lack of resource for services; difficulties of complex cases when victims/survivors have multiple needs; and barriers to access – especially for particular communities such as migrants, disabled women and LGBTQIA+ were apparent.

Interview Findings

Although we only had two interviewees, their narratives exemplified many of the issues highlighted by both the survey and focus group findings. Interview responses were coded grouped into overall themes, to highlight key, repeated points relating to the research questions. Each of these themes will be discussed in turn with exemplar quotations used from both participants to highlight some of the main points made.

Accessing help initially

How help was initially accessed involved a combination of going on-line to do their own research, getting advice from a friend, contacting Citizens Advice and being directed to specialist services such as Yellow Door.

One interviewee initially made via a phone call but highlighted:

> *"sites where you had like chats where you can actually talk to people on the chat that helps massively" (Maya)*

Another had issues when posted information was found by her abuser so would have preferred face to face interaction:

> *"A perfect scenario would be if I made that call if I could see someone face to face, let them come and see me my home my children how we are and have a communication and not be like you know what we could send you post - more confidential, I think even to call me by another name or anything. And to make me feel that I could do it, that this is there's no fear" (Rhea)*

Good practice or things that worked well

There were various examples of things agencies did which worked well. This included good practice by certain individuals in the police (e.g. giving advice), social work (taking allegations seriously) and at court (e.g. a judge taking children into chambers). In relation to things that worked well from support services the main thing highlighted was that it was

> *"good to actually be able to speak to someone… them being so understanding… I didn't have to prove myself… when I reached out to Stop Domestic Abuse, and I spoke to whoever was on the phone, they were amazing. They really like made me feel like I was being heard… what do I want?... What can she do?" (Maya)*

Both interviewees described the usefulness of courses regarding healthy relationships and being assigned to specific support workers. Maya appreciated the support worker's knowledge and assistance before and during their meetings,

> *"she has done all her research. So without me having to without her having to say to me, this is what we need to do. And I need you to do this" (Maya)*

She also highlighted how having a support worker with a similar Muslim background really assisted,

> *"it helps with like, other things like just things that I don't have to mention to her, she already knows things" (Maya)*

> *"it's not like, oh, I need someone to be, you know, Muslim, for them to understand… I'm just saying with Yellow Door, I was assigned with someone that was Muslim. So it's actually helped. I didn't have to, like mention anything -or say anything, she had already done, like the thinking for me. And that really helps, it really does just take that weight off your shoulder" (Maya)*

> *"she also gave me a number for one of the Imams, its Imam… and she even helped me with what sort of questions that I should be asking… That was that was really good" (Maya)*

Secondary victimisation

Both interviewees described things they felt had not helped – for example believing someone would help and then being let down, in some instances making the situation even worse.

This was not down to one specific service. Poor or unexpected responses were noted from different agencies, including health, criminal justice, education and social work:

> *"She [GP] didn't really send me any links or anything like that. And she gave me whichever medication to kind of help me… she could have followed up" (Maya)*

> *"even when I went to school when the teachers knew I was going through something" (Rhea)*

> *"the authority let me down. How the judges have saying hindsight… my hands are tied… Things should have been like done like this… even… with my evidence…. It wasn't just me, they let my son down" (Rhea)*

> *"They [police] said it's a civil matter. But there's violence involved… if the police turned up, I wouldn't go through all this… they keep saying we don't have the resource… I wish there was more understanding they could have nipped in the bud they could have stopped all this" (Rhea)*

> *"they did let me down the CAFCASS[1]. The social worker, the safeguard, the police, every one of them" (Rhea)*

A lack of community knowledge regarding systems designed to assist was also mentioned

> *"why can't this be given when I actually made that effort to call that helpline and say I need to help. And I see these ads, you know, when ladies go into toilet have something on their hand to say help… I used that didn't work. A lot of people didn't even know what it meant" (Rhea)*

Even when in a refuge – some things were made harder.

> *I was bleeding like hell. I got no help… they said you know what? You have to walk to the doctor which is so far away. I had no pushchair [for baby as left in a hurry]. I wasn't allowed to call a taxi because you're not allowed reveal identity. I drive I said look can somebody get my car?... No, you're not allowed to. They gave me no choice. It was so difficult. I was literally like they're not making this any easier even with this (Rhea)*

This links to some basic needs victims/survivors may have, which was also explored.

Needs

Both interviewees were explicit in the needs they had. Some of these were general and could potentially be applied to all victims/survivors of domestic abuse. These included not only what they required such as timely access to services, or knowledge due to inexperience of being in this type of situation; but also help with issues like feeling alone, being anxious regarding what may happen, or wanting to be listened to. In addition, bespoke needs of individuals belonging to certain groups were highlighted –

such as bespoke needs of Muslim women. As such this theme has been split into two subthemes of general, and bespoke needs.

General needs

Both interviewees needed assistance as this was a novel situation for them and they wanted to feel supported and protected by professionals with experience:

> *“I didn't know what honour based was, I didn't know what domestic violence was” (Rhea)*
>
> *Why wasn't there a [police] officer that had more understanding of domestic violence? Well, why did I have random officer that had no idea and very, like, you know, you know, we're here, what's happened tell us? There was no empathy, there was nothing to say… you know what, you're protected (Rhea)*
>
> *“Take him away, tell him he cannot come back. Then speak to me what I want to do, tell me that I'm being reassured, tell me, you're not alone. Tell me we're here to help you” (Rhea)*

The feeling of being alone was repeatedly highlighted as was a sense of anxiety about what would happen;

> *“everyone [family] kind of didn't understand” (Maya)*
>
> *“I had no one. I literally had a CID officer. I had a safeguarding guy, and I had random police officers coming back and forth…I didn’t even have a phone to use” (Rhea)*
>
> *“I said please just take me home. I beg you. And they said no, we can't. You're in danger. And my kids are in danger I left my kids please” (Rhea)*
>
> *“I've got no hope” (Rhea)*

Types of practical advice and financial support were required including knowing what support was available, applying for child maintenance, access to a refuge, court orders and housing:

> *“I didn't have internet, I was not good with technology” (Rhea)*
>
> *“My solicitor says to me, the best thing to do is look for a flat… so how am I going to afford this? I have a house that can't pay mortgage… I'm paying housing benefit to the refuge. And I don't know about this kind of stuff is so complicated… I don't even know the place at all… they found this really horrible place I goes I'm not going there. My kids will never come” (Rhea)*
>
> *There was nothing because I left everything in the flat… no TV… It was so cold… my dad bought food… some duvets and blow up mattresses” (Rhea)*

They also highlighted how they wanted to be listened to:

> *“I was being heard” (Maya)*
>
> *“Nobody cared. Nobody listened to us… my voice didn’t matter” (Rhea)*

Specific suggestions regarding support services were made:

> *"if you're going to speak to me, that's fine. I don't want to see 10 different people" (Rhea)*

Bespoke needs

As highlighted above, one of the positive things reported by one interviewee was having a Muslim support worker to assist her. She highlighted the mutual understanding of culture was useful:

> *"So as a Muslim… it's really difficult for a woman to get a divorce from the man. So I think that would help massively actually, if that's something that that can be seen... different religions, and how do you actually get a divorce, like within your religion? But with women in Islam… she has to fight for it… it's quite important to kind of understand what kind of help they would need" (Maya)*

Rhea also highlighted needs of minority individuals including knowledge of the language, systems and ways to access support within a different country and culture.

Other bespoke intersectional needs were discussed:

> *"I do suffer from like, anxiety. And like, I'm quite stressed and things as well. So when it comes to even making phone calls, it's really difficult for me and I have asked… if they can be there with me while I make phone calls" (Maya)*

In summary the two interviews highlighted some striking similarities to the findings of the surveys. The general needs and usefulness of the variety of services were acknowledged, in particular the need for emotional support and having someone to listen to them. Beyond the general barriers to gaining assistance explored in the surveys and focus group, the interviews gave detailed examples of secondary victimisation whereby the participants at times felt let down, and even re-victimised by the services designed to assist them. Moreover, bespoke assistance of having support from individuals from the same cultural background (Muslim) was unpacked, with examples given of how and why this helped them greatly.

Discussion

The findings from the survey, focus group and interview data are consistent overall, with several key themes emerging. These are mapped in Figure 4 and will be summarised in turn.

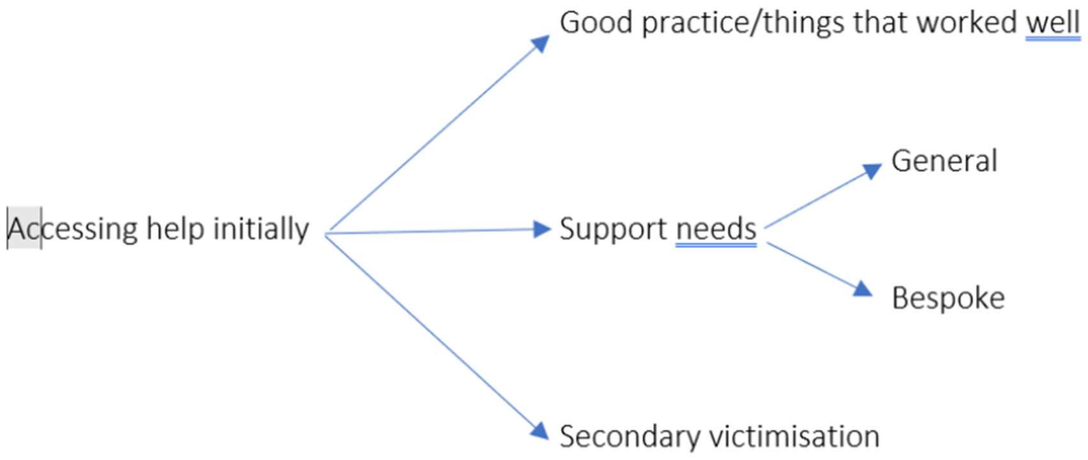

Figure 5 - Mapping of Main Themes

Accessing help: There was a great deal of information provided by participants in relation to how they accessed help, with a variety of methods (using research on-line, being referred by agencies), however some difficulties were noted. Some barriers to accessing support were personal - embarrassment or shame, closely followed by fear of what might happen, and not being believed. This may be particularly pertinent for certain groups, for example our findings reflected those of Sheer et al. (2023) who found two of their sample did not seek help because they did not want to contribute to the negative perceptions of the LGBTQIA+ community. Similarly cultural shame and guilt were noted by some of the BME participants quotes outlined above. Whilst is not clear if shame aligns to 'allowing themselves' to be in that situation, or bringing 'shame' on to the community, either way it is important for support services to recognise this form of 'self' victim blaming as a potential barrier for accessing help.

Other barriers to accessing support were more practical (e.g. could not physically get to them; did not recognise what was happening was abuse) or organisational (no local availability). The main difficulties related to knowing how/where to get advice; often being passed around different agencies (particularly for those with complex/multiple needs; and the high demand for services meaning lengthy wait times. Participants highlighted the need for local, accessible services, which were bespoke to individual needs. For example some preferred face to face engagement, others preferring phone calls or texts.

Support needs – general: Once support was accessed, clients wanted long term support, often citing that limited numbers of sessions, or a lack of follow up contact was insufficient to deal with the effects of long-term trauma. The most common victim/survivor needs were in relation to emotional support with requirements from mental health support or counselling. This might be because victims/survivors are choosing to pay to access such services, but it could also be that they see these as the most valuable. It is unclear as to whether mental health issues may be part of the cause of the abuse - studies have found that people who have a history of mental health conditions are likely to have increased odds of experiencing intimate partner violence and abuse (Brownridge et al. 2022, Du Mont and Forte, 2014); or it may be the effect of such abuse as there is a direct link between increased rates of mental health issues such as depression in women who experience DA (Humphreys & Thiara, 2003, White et al. 2024). Yet regardless of the cause of the mental health issues, this is important for support service providers to acknowledge and support. This may impact an individual's ability to engage with services which, may already be anxiety provoking.

Practical assistance was also required from support services – help with children, legal or financial issues. The need for victims/survivors to be listened to was highlighted throughout, and for their many anxieties and concerns to be taken into account.

Housing issues were seen as key by the practitioners involved in the focus group. As an area it is understood that Southampton has unique population demographics and socio-spatial environment. Service users may be resistant to move within and across Southampton due to stereotypes and misperceptions about different locations, and, although the population is large, there is a sense that 'everybody knows your business' making service users wary and potentially less likely to engage. National shortages of housing stock and chronic underfunding of DA services more generally means some DA service providers are currently unable to fully meet the needs of all members of their communities.

Furthermore, service provision, as impacted by funding and availability of resources suggests that, as indicated above, those who are deemed 'medium risk' may miss opportunities for support services. The view presented from the focus group suggested that a medium risk victim-survivor may be more difficult to engage with as they have to consent. Providers may need to consider how best to improve training for professionals to ensure a client is engaging and actively chose to get support, regardless of level of risk.

Support needs - bespoke: It was highlighted that some groups and communities may require bespoke help – for example BME individuals may have language difficulties, or abuse may be normalised within their family/culture. Disabled people may have additional difficulties accessing services or be reliant upon their abusers for day-to-day care. LGBTQIA+ persons may have bespoke needs – for example may have additional isolation if they lack support from family/friends. It was repeatedly mentioned that bespoke assistance, from those within the different communities, who have greater understanding of particular circumstances and needs, is essential for such groups. However, access to such individuals may be currently limited within Southampton.

Another interesting point to note in relation to the minority groups who completed the survey was that an assumption is made that people who are disabled, BME or who identify as LGBTQIA+ automatically feel and become part of that community, however our results show that this is not necessarily the case. This implications for this are that although it is important to have targeted support and marketing regarding who can access that support; it is also important to ensure that all communication is clear about the support on offer to include the diverse groups no matter how they do (or do not) identify.

This report also highlighted a gap in services for male victims/survivors which may be of interest for consideration in future bespoke support. Some of the findings here reflect previous research which found differences in the way male (compared to female) victims/survivors conceptualise DA (Laskey et al. 2019). For example in one study, men reported they would be more likely to minimise the abuse and less likely to disclose (Arnocky et al, 2014, Hine et al. 2020). Another study found three of the five barriers to accessing support were similar to those of women - fear of disclosure aligned to shame, commitment to the relationship and reduced self-esteem (‘diminished confidence’), however two were unique to men, one around the role of masculinity and the other their invisibility to services (Huntley, et al. 2018). Moreover, traditional, and unhelpful expectations of gender roles/norms have been found to negatively impact their seeking help when experiencing DA (Hine et al, 2020).

Good practice – things that worked well: Many areas of good practice or things which worked for victims/survivors were noted. In particular the overwhelming support of services and staff of different agencies were commended, and the majority of participants found services useful. Some very impactful comments were made indicating some participants may not be here today if it wasn’t for the support they had received. Good practice was noted in terms of housing initiatives, support and courses attended, and the provision of bespoke (e.g. Muslim; LGBTQIA+) support workers who provided an additional layer of understanding.

Secondary victimisation – things that could be improved: Conversely there were also criticisms of services and recommendations for improvements in these research findings. Whilst some of these were not directly related to charitable support services per se, some had significant negative impacts for victims/survivors. Many recounted the secondary victimisation they experienced – making their situations even worse than they were previously. These were often linked to being let down – thinking someone would help and then being passed elsewhere or not receiving anticipated assistance. Elements of what some participants outlined reflected a previous Yellow Door report (Olabanji, 2022) who noted that people who have experienced DA from BME communities had previous experience with services mistrusting them, which had harmful consequences for themselves or family members. This was also born out though the interviews where one participant’s experience of dealing with the criminal justice service in particular was harrowing, reflecting what Bostock et al. (2009) found - the way services responded to victims/survivors, if it was not done with care could reinforce the abuse.

Moreover, it was disappointing to find that over a quarter of participants had concerns about losing children, and one of our interviewees experienced this. A common finding was women staying in unsafe environments to protect their children or not wanting to move to refuges without them. It should not be underestimated what victims/survivors will be willing to sacrifice for the sake of protecting their children and this real fear and driver needs to be recognised by professionals and should not be a barrier to accessing support.

Limitations and future research

Overall it was felt the survey responses provided a representative sample for the requirements of this study. However the sample sizes for participants of the interviews and focus groups were somewhat disappointing. It is recognised that subjecting victims/survivors to re-discuss anything to do with their abuse may be traumatic; and we acknowledge that many working in this and related fields are very busy. As such whilst repeated attempts were made to increase the samples of these latter two groups, it was felt the information received from the participants obtained was sufficient, and the findings reinforced those from the larger survey sample.

One of the limitations subsequently identified with the survey was our use of self-defining questions in regard to ethnicity, sexual orientation, gender and religion. Whilst we did this to ensure inclusivity, this resulted in some answers being hard to interpret - for example, if participants who cited ‘British’ under ethnicity and nationality were part of the White or BME community; or how to distinguish British BME individuals from migrants overseas. Future research may want to tease out different communities.

One theme which was apparent throughout the research, yet was not explored in any depth due to the focus upon the research questions, was the severe impact domestic violence and abuse has on victims/survivors/family and friends. Throughout the interviews and survey data, participants described extensive physical and mental ill-health resulting from their traumatic experiences both directly at the hands of their abusers and vicariously. We felt this should at least be acknowledged.

Conclusion

We hope this report has provided some clarity in relation to the original research questions outlined:

Research Question 1: What are the support services currently doing well?
It seems support services are offering many services victims/survivors need, particularly in relation to emotional support. Staff of support services were held in high regard and elements of good practice in providing services tailored to individual needs were apparent. In light of some comments, services are deemed not only useful, but essential for survival, wellbeing and recovery. As such it is strongly recommended that current delivery of services continue, and moreover are enhanced with increased provision going forward.

Research Question 2: What could be improved by support services?
Unfortunately for many, recognition of abuse, and then gaining access to services was difficult due to being passed to different services, and lengthy waiting lists – all of which acted as significant barriers to gaining support. Additional poor practice by a variety of agencies was noted, some with significant negative impacts incorporating secondary victimisation. Victims/survivors described being let down, necessitating the need for even greater service support. In terms of future commissioning enhancing timely access to services, and enhanced training for professionals, and awareness of the general public in relation to what constitutes domestic abuse, is a significant need.

Research Question 3: Do LBGTQIA+, BME or disabled people have specific support service needs?
Overwhelmingly most participants noted the bespoke needs of specific communities. Provision of by and for services from those of similar backgrounds was repeatedly encouraged due to the greater level of knowledge and understanding they posses. In terms of both commissioning of bespoke services, and delivery of those services by and for people with bespoke needs, is strongly recommended in order to offer inclusive services for all.

Finally, we thank everyone for their support in this project, obviously the participants themselves, but in particular the staff of the support services - we have been overwhelmed gleaning a deeper insight to the support they provide, and hope this report goes some way to ensure services are improved even further for all of the community going forward.

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Appendices

Appendix A: Coding for Qualitative Analysis – Interviews

Stage 1:

Codes	**Definition**
Identification	How help was initially identified – e.g. friend suggested
Initial contact	Initial contact for help – e.g. phone call to xxx
Good practice	Things that the client thought worked well/helped them
Poor practice	Things that the client felt could be improved/what went wrong
Impact	Impact of the abuse on the client/family
Client needs	Things the client needed support with
Family	Family helping/hindering
Taking control	How the client attempted to take control or reference to this
Fear	Mention of fear in self/others
GP	GP response/involvement in disclosures
Self-blame	Discussion of blaming self for what happened
Alone/new	Feeling alone or that this experience was new/inexperience in dealing with it
Having a voice	Importance of feeling heard – themselves or others (e.g. children)
Other support	Support offered by those other than agencies/support services
Messy situation	Description of situation as messy/confused
Anxiety	Feeling anxiety towards what may happen in the future
Having to fight	Needing to fight - e.g. for divorce in certain communities
Bespoke needs	Needs of specific communities – e.g. BAME
Self-evaluation	Evaluating oneself/actions with hindsight
Have tried	Describing having tried - e.g. to help children
Length of time	Consideration of the length of time things took – e.g. court cases
Being let down	Describing or inferring they have been let down by others
Hope	Hope of a better future
Gaslighting	Gaslighting as a form of abuse

Those in bold witnessed in both interviews.

Stage 2:

Codes	Outcome
Identification	Kept
Initial contact	Kept
Good practice	Made into a theme
Poor practice	Made into a theme
Impact	Deleted – limited relevance to RQ
Client needs	Made into a theme
Family	Merged into client needs
Taking control	Deleted – limited relevance to RQ
Fear	Deleted – limited relevance to RQ
GP	Merged into good/poor practice
Self-blame	Merged into self-evaluation
Alone/new	Split into alone and lack of knowledge
Having a voice	Kept
Other support	Deleted – limited relevance to RQ
Messy situation	Deleted – limited relevance to RQ
Anxiety	Kept
Having to fight	Deleted – limited relevance to RQ
Bespoke needs	Kept
Self-evaluation	Kept
Have tried	Merged into self-evaluation
Length of time	Kept
Being let down	Kept
Hope	Deleted – limited relevance to RQ
Gaslighting	Deleted – limited relevance to RQ

Stage 3:

Themes	**Codes**
Accessing help initially	Identification
	Initial contact
Good practice	Good practice
Secondary victimisation	Poor practice
	Being let down
Needs	Client needs
	Bespoke needs - subtheme
	Having a voice
	Length of time
	Alone
	Lack of knowledge
	Anxiety re what will happen
	Self-evaluation

Those in italics were deleted due to limited relevance to RQ

Appendix B: Coding for Qualitative Analysis – Focus Groups

Stage 1:

Codes	**Definition**
Barriers	Includes both micro and macro barriers to engaging with services, includes minority groups
Complex cases	Professionals sense that more complex cases are being presented, requiring greater care; complexity in intersectional requirements
Inter-agency working	Success and barriers to work collaboratively across agencies in Southampton
Changes in practice	Where there are changes to local and national trends, such as enabling women to remain in their own homes, perp programmes available, focus on male offender behaviour
Southampton as unique location	Specific practices, needs and geography of Southampton and the impact of this on service provision
Housing issues	Barriers and successes in housing provision; overlaps with inter-agency working above in places
Training and Training needs (combined codes during stage 2)	What training provision is available; what training needs exist
Service User Focus	Prioritising victim-survivor in language, practice, and policy
Perpetrators and Perpetrator Programmes (combined codes during Stage 2)	Comments in relation to the perpetrators, including programmes of support (not directly relevant to RQs but coded)
Support	Support organisations, both formal and informal, from different groups, includes charities, religious groups, ISVA, IDVA, housing, other projects, and neighbourhood/family support

Themes:
Stage 1:
Intersections of complex cases with demand for housing and housing stock; barriers (micro and macro, individual and structural); inter-agency comms, uniqueness of Southampton as location.
Stage 2:
RQ1 – what are services currently doing well: developed themes on the intersections of housing and DA, plus changes in practice on DA.
RQ2 – what could be improved by services: developed themes on the barriers at micro and macro level, including additional barriers for minoritised groups, barriers within Southampton itself, and lack of funding nationally on service provision.
RQ3 – do BDL have specific service needs: developed themes on the intersectional nature of demand and supply, the value of lived experience in support.

Appendix C: Qualitative Survey codes

Stage 1:

Codes	Definition
Identification	How help was initially identified – e.g. friend suggested
Initial contact	Initial contact for help – e.g. phone call to xxx
Good practice	Things that the client thought worked well/helped them
Poor practice	Things that the client felt could be improved/what went wrong
Being let down	Describing or inferring they have been let down by others
Client needs	Things the client needed support with
Bespoke needs	Needs of specific communities – e.g. BAME
Having a voice	Importance of feeling heard – themselves or others (e.g. children)
Length of time	Consideration of the length of time things took – e.g. court cases
Alone	Feeling alone
Lack of knowledge	Feeling this experience was new/inexperience in dealing with it
Anxiety	Feeling anxiety towards what may happen in the future

Stage 2:

Themes	Codes
Accessing help initially	Identification
	Initial contact
Good practice	Good practice
Secondary victimisation	Poor practice
	Being let down
Needs	Client needs
	Bespoke needs - subtheme
	Having a voice
	Length of time
	Alone
	Lack of knowledge
	Anxiety re what will happen

Appendix D: Postcodes of Respondents

Postcodes	No. Of Participants (n=151)	Percentage (%)
SO14	11	7.2
SO15	17	5.8
SO16	20	13.2
SO17	9	6.0
SO18	18	11.9
SO19	25	16.6
SO30	2	1.3
SO31	5	3.3
SO40	6	3.9
SO41	4	2.6
SO45	7	4.6
SO50	6	3.9
SO52	3	2.0
SO53	3	2.0
BH	5	3.3
SP	3	2.0
PO	7	4.6

Appendix E: Ethnicities of Respondents

Ethnicity	No. Of Participants (n=292)	Percentage (%)
African	3	1.0
Arab	1	0.3
Asian	4	1.3
Asian Indian	1	0.3
Asian other	1	0.3
Bangladeshi	2	0.7
Black	1	0.3
Black / white	1	0.3
Black African	3	1.0
British	25	8.6
British (Black)	1	0.3
British (white)	92	31.5
Caribbean	1	0.3
Caucasian	5	1.7
Chinese	2	0.7
English	1	0.3
European	1	0.3
European, bit of a mixture	1	0.3
Indian	2	0.7
Irish	1	0.3
Italian	1	0.3
Lithuanian	1	0.3
Mixed - Asian and white	1	0.3
Mixed - White/Mauritian	1	0.3
Mixed white/black Caribbean	3	1.0
Pakistani	2	0.7
White	120	41.1
White Caucasian	2	0.7
White English	5	1.7
White European	2	0.7
White half English half Italian	1	0.3
white Irish	2	0.7
White Slavic	1	0.3
white Welsh	1	0.3

Appendix F: Nationalities of Respondents

Nationality	No. Of Participants (n=289)	Percentage (%)
Black African	1	0.3
Botswanan	1	0.3
British	216	74.7
English	36	9.3
UK	3	0.9
British Indian	1	0.3
British Irish	1	0.3
British, French	1	0.3
British, south African	1	0.3
Cameroonian CM	1	0.3
Chilean	1	0.3
French	1	0.3
German	1	0.3
Hong Kong	1	0.3
Indian	1	0.3
Irish	2	0.6
Italian	2	0.6
Lithuanian	1	0.3
Motswana	1	0.3
Namibian	2	0.6
Pakistani	1	0.3
Polish	4	1.2
Portuguese	2	0.6
Romanian	2	0.6
Saudi Arabia	1	0.3
Slovak	1	0.3
Sri Lankan	1	0.3
Welsh	1	0.3
Zimbabwean	1	0.3

Appendix G: Other Disabilities of Respondents

Description of Disability	No. of participants	Percentage (%)
No bowel control, Panic attacks Awaiting assessment for ADHD and autism	1	0.3
Ageing	1	0.3
Chronic fatigue and pain post stroke	1	0.3
Chronic illness	1	0.3
Chronic neurological illness	1	0.3
Chronic pain / fatigue	1	0.3
COPD	1	0.3
Diabetic	1	0.3
Epilepsy	1	0.3
Epilepsy, AVM on the brain	1	0.3
Functional Neurological Disorder	1	0.3
Functional Neurological Disorder. Chronic Pain Syndrome, Chronic Fatigue Syndrome, to name a few of my conditions!!!!	1	0.3
joint hypermobility	1	0.3
Loads of medical issues	1	0.3
Mobility where I use a Mobility scooter to get around and mental health and learning disability mental age off a 14yr	1	0.3
Scoliosis	1	0.3
Tourette’s, nervous system conditions,	1	0.3
Type 1 diabetic, kidney disease	1	0.3
Undiagnosed ADHD.	1	0.3

Appendix H: Other Services Accessed

Service accessed (Other) *	Number of participants
Adapt	1
ChildLine	1
Cisters	1
Citizen's Advice	1
Counselling	1
Doctor & surgery reception	2
DV counsellor	1
Eastleigh Borough COUNCIL	1
Emergency intervention team council	1
Finding Freedom from Abuse, Andover	1
FJC Croydon	1
Hampton Trust	1
IDAS	1
IDVA	4
Italk	1
Mental health coach at GP	1
MIND	1
MK ACT	1
Modern day slavery	1
NAPAC	1
No Limits	4
Paragon	2
Parcs	1
PIPPA	1
Police	3
Private psychiatrist	1
Rape and sexual violence project Birmingham	1
Refuge (did not specify type)	3
Respect phoneline	1
Revenge Porn Helpline	1
Salvation army	1
Samaritans	2
SCC IDVA service	1
Services in France	1
Social Services	2
Southampton City Council	2
Southern Domistic Helpline ?? (was renamed)	1
Stars	1
Steps to Wellbeing	5
Support worker from local council	1

Sure start group	1
The freedom project	1
The Hampton Trust	1
TREVI	1
University counselling service	1
Various services	3
Victim Support via Police	1
Women's Aid	7
Women’s Refuge	3
The You Trust	8
Your Sanctuary, Woking	1

*We have separated out those that noted a specific region for a service

Appendix I: Responses for Southampton residents

The following data is for survey respondents who replied ‘yes’ to ‘Do you live in Southampton’, n=212.

Gender:

Gender	No of Participants N=212	Percentage
Female	164	77%
Male	18	9%
Non-binary	7	3%
Transgender	4	<4%
Queer	2	<1%
Asexual	1	<1%
Other (transmasculine, gender queer)	1	<1%
Chose not to answer	15	7%

Sexual Orientation:

Sexual Orientation	No of Participants N=212	Percentage
Straight/Heterosexual	143	67%
Bisexual	40	19%
Lesbian	5	2%
Gay	5	2%
Aseuxal, Queer, Pansexual	0	0
Other	12	6%
Chose not to answer	6	3%

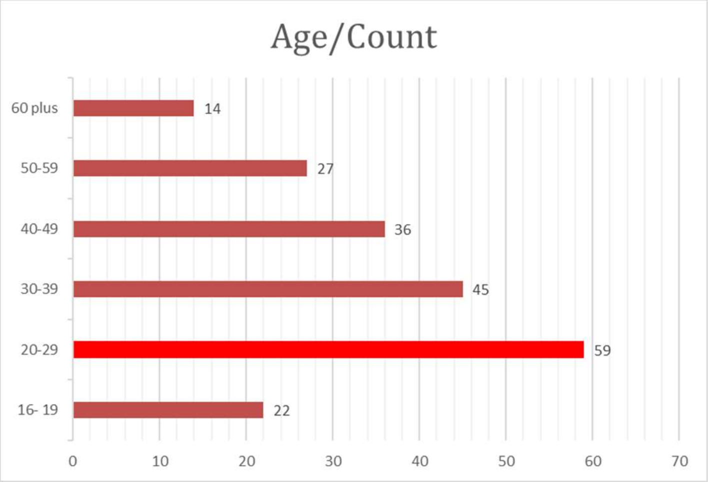
Ethnicity and Disability:

BME	24
Not BME	160
Disabled	105
Non disabled	102

Nationality:

Nationality	Count
Black African	1
Botswanian	1
British	153
British Indian	1
British Irish	1
British French	1
British South African	1
Cameroonian	1
Chilean	1
English	21
French	1
Hong Kong	1
Irish	1
Italian	1
Lithuanian	1
Namibian	1
Pakistani	1
Polish	1
Romanian	1
Slovak	1
Sri Lankan	1
Welsh	1

Age:



Barriers to accessing support (for those who said ‘yes’, Q7, n=119)

Barriers to accessing support	No. of Respondents N=119	Percentage % (rounded)
Fear of what might happen	74	62
Fear of not being believed	71	60
Embarrassment or shame	71	60
Not recognising it as abuse	69	58
Denial	53	45
Worry about information sharing	46	39
Hope things will change	41	34
Not a big deal	36	30
Worry about finances	33	28
Love for abuser	32	27
Access	32	27
Worry about losing access to children	30	25
Loyalty to abuser	30	25
Worry about housing	30	25
Worry about losing family and friends	29	24
Other	10	7