Article

Not peer-reviewed version

Contemporary treatment of crime victim/survivors: Barriers faced by minority groups in accessing and utilizing domestic abuse services

Terri Cole * , Orlanda Harvey , Jane Healy , Chloe Smith

Posted Date: 29 November 2024

doi: 10.20944/preprints202411.2348.v1

Keywords: victim; survivor; support; domestic abuse; domestic violence; intimate partner violence; LGBTQIA+; BME; disabled people; minority groups

Article

Contemporary Treatment of Crime Victim/Survivors: Barriers Faced by Minority Groups in Accessing and Utilizing Domestic Abuse Services

Terri Cole *, Orlanda Harvey, Jane Healy and Chloe Smith

Bournemouth University
* Correspondence: Bournemouth University, tcole@bournemouth.ac.uk

Abstract: This research explored the experiences of LGBTQIA+, black and ethnic minority (BME), and disabled victims of domestic abuse due to the frequency of abuse in these populations and bespoke needs they may have. Data was collected via an online survey (n=317), a focus group with professionals (n=2), and interviews with victim/survivors of domestic abuse (n=2). Many articulated difficulties in accessing support for many reasons, including individual and structural barriers - such as embarrassment, stigma, shame, fear and not being aware of what support is available. Whilst good practice was reported, examples of secondary victimization towards victim/survivors by individuals, professionals and organizations were recounted. Many barriers were identified, for example there was inappropriate provision in refuges or shelters for LGBTQIA+ groups or disabled people. Disabled victims experienced additional barriers if their abuser was also their carer. BME groups may have additional language difficulties as well as cultural stigma and pressure to stay with their abuser. Recommendations for practice include the need for enhanced multi-agency training and recognition of abuse; crime victim/survivors being supported by someone with the same cultural background; easier access to interpreters; and more appropriate refuge or alternative housing options.

Keywords: victim; survivor; support; domestic abuse; domestic violence; intimate partner violence; LGBTQIA+; BME; disabled people; minority groups

---

1. Introduction

1.1. Definitions and Prevalence

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 physical, sexual, violent or threatening, psychological, emotional, economic, controlling and/or coercive behaviour. It can involve a single incident or pattern of behaviour. Within DA is intimate partner violence and abuse (IPVA) where individuals have a personal connection – i.e. are due to be, currently are, or have been in an intimate relationship with each other (Ellseberg et al. 2008). It is estimated 2.1 million people (1.4 million women and 751,000 men) in England and Wales experienced domestic abuse in the year ending March 2023 (ONS, 2023), and prevalence data from 161 countries found nearly 1 in 3 women have been subjected to either physical and/or sexual intimate partner violence or non partner sexual violence (WHO, 2018).

DA/IPVA occurs in all society, however emergent research suggests increased prevalence within certain minority communities such as: LGBTQIA+ (New Jersey Institute of Technology, 2022); BME (Interventions Alliance, 2021); and disabled people (Magowan, 2003). The authors acknowledge discussions regarding terminology of abuse (Romero-Sánchez et al., 2021), therefore throughout this paper will use the all-encompassing term victim/survivors.

1.1.1. LGBTQIA+ Victim/Survivors

Prevalence statistics do not always include sexuality or gender identity, however a national survey of the Lesbian Gay Bisexual Transgender Queer Intersex Asexual (LGBTQIA)+ community in the UK found one in four lesbian and bisexual women (25%) have experienced DA (Guasp, 2011). Research in relation to gay men found nearly 12% reported experiencing physical violence (Stephenson et al., 2022), another study reporting 86% of young gay men had been subject to psychological aggression, 67% experienced physical assault, and 64% experienced sexual coercion (Kubicek et al., 2016). Disparity between reporting levels may be due to different methods and samples, however the overall prevalence is alarming. Others have found high rates of DA reported by bisexual people - a lifetime prevalence for rape, physical violence, and stalking was reported by 61% of bisexual women and 27% of bisexual men (CDC, 2013) and Peitzmeier et al., (2020) found transgender individuals were twice as likely to experience DA than cisgendered counterparts. One study found more than two-thirds of female-to-male individuals had experienced DA (McDowell et al., 2019).

1.1.2. BME Victim/Survivors

The Crime Survey for England and Wales (ONS, 2023) reports a higher percentage of victim/survivors of DA were Black and Minority Ethnic (BME). Others have found (Iob et al., 2020) BME groups made up nearly 13% of victim/survivors of psychological abuse and over 4% physical abuse. Afrouz et al, (2018) found women from communities in which family abuse is normalised were less likely to seek help, to protect the family's reputation. In Pakistan one study found only 14% of 7,897 women who experienced physical abuse reported to police, most not reporting to anyone outside their family (Andersson et al, 2010). In a US study, many migrant women choose not to leave relationships due to cultural and religious ties (Ammar et al, 2013). Resultingly, UK organisations supporting victim/survivors are seeking partnerships with specialist services that provide culturally sensitive support for BME communities (Olabanji, 2022).

1.1.3. Disabled Victim/Survivors

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). The term disability covers a variety of conditions, impairments and disorders which may enhance the risks of experiencing DA. For example, 38% of people with physical disabilities had experienced physical abuse, and 23% economic abuse (Fanslow et al., 2021). Disabled women are 30% more likely to experience DA compared to non-disabled (Emerson & Llewllyn, 2023). Nineteen percent of individuals with learning disabilities had experienced DA in the year prior to data collection (ONS, 2022) and adults with Autistic Spectrum Condition (ASC) were nearly twice as likely to experience DA than those without such diagnoses (Griffiths et al., 2019). One sample of 79 people with schizophrenia found 73% had experienced DA (Afe et al., 2017). Additionally, over 70% of hearing-impaired women had experienced psychological abuse (Johnston-McCabe et al., 2011) and 1 in 12 visually impaired individuals had experienced DA (Coles et al., 2022). As such, there is significant evidence that disabled women are at increased risk of DA (Balderston, 2013; Healy, 2021; Hughes et al., 2012; Pettitt et al., 2013; Thiara & Hague, 2013).

In summary, accurate levels of prevalence are limited due to a lack of reporting, however, findings suggest these communities experience higher rates of DA.

1.2. Accessing Support

Although support is provided through statutory bodies, the charity sector plays a critical role in responding to DA in recent years, working with both victim/survivors and perpetrators (Ablaza et al., 2022; Olabanjii, 2022). Yet despite such experience and an awareness of limitations (e.g. Fugate et al., 2005), recent research highlights many barriers are still faced by victim/survivors in accessing support (Heron et al. 2022) including shame, difficulty recognising the abuse, and ongoing behaviour by the abuser (Couto et al., 2023, Heron et al., 2022). These barriers may be exacerbated in specific communities.

1.2.1. Barriers for LGBTQIA+ Victim/Survivors

The problematic nature of gendered stereotypes in encounters of DA may lead to enhanced difficulties in accessing help for the LGBTQIA+ community. Some lesbian victims/survivors report being arrested rather than supported, because they were perceived as 'butch' or more 'masculine' in their relationship (Hassouneh & Glass, 2008). Physical abuse towards gay men may be ignored as features such as 'rough sex' may be perceived as 'normal' in such relationships (Maxwell et al., 2022). Others may not want to contribute to negative perceptions of the LGBTQIA+ community by reporting (Scheer et al., 2023).

1.2.2. Barriers for BME Victim/Survivors

SafeLives (2015) found 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), and difficulties may be particularly acute for migrant women (Graca, 2017). Reasons include potential fear about leaving their relationship (Hulley et al., 2023), that their children will be removed (Anitha, 2008; AVA, 2022) or cultural sensitivities which encourage victim/survivors to keep things 'within the family' (SafeLives, 2017).

1.2.3. Barriers for Disabled Victim/Survivors

If victims/survivors are reliant on their abuser for their care, DA can be even more difficult to escape (Sin, 2015). Structural factors such as a lack of accessible refuge provision can further prohibit their leaving (Thiara & Hague, 2013).

1.3. Purpose of the Current Research

There is very limited previous research investigating the bespoke needs of such communities when it comes to treatment, care and support for DA. As such the focus of this research was to establish how specialist services can be tailored to encourage help-seeking and identify bespoke needs these groups they may have.

The three research questions were:

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

2. Materials and Methods

Three simultaneous studies were conducted to explore experiences and needs.

2.1. Surveys – General Public

An online survey was sent to adults, focusing on those living in Southampton (UK). It was disseminated via social media, and via a total of 88 charities and community groups specialising in support for LGBTQIA+, BME and disabled people. It was designed using JISC Online Surveys and disseminated via an online link which was 'live' from September - December 2023. The survey included a mix of tick box and free text answers. It collated experiences of DA, asking views on support needs for victim/survivors, and questions regarding 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. The survey collected demographic information in relation to gender identity, sexual orientation, age, disability, ethnicity, and sexual orientation. This information was used both to classify survey responses, and ensure responses were representative of a variety of individuals.

2.2. Focus Group - Practitioners

Despite contacting 30 organisations representing the minority groups and providers of DA support, only two participants attended an arranged session.

2.3. Interviews – Victim/Survivors

The research design was to interview those with lived experiences from each of the three groups (LGBTQIA+, BME, and disabled people) who had accessed DA services, however only two agreed to be interviewed. Interviews were semi-structured, conducted via Zoom and audio recorded with permission of the interviewee. Support was provided directly after the interview and information regarding additional support provided.

2.4. Ethics

Full ethical approval was obtained in line with the Bournemouth University ethical codes and the UKRI's research ethics framework. Representatives from commissioning organisations reviewed draft research designs, answering questions was optional for participants, and pseudonyms were used throughout to maintain anonymity.

2.5. Analysis

The fieldwork consisted of quantitative data - from 'tick box' survey responses; and qualitative data from free-text survey answers, focus group and interview data. This mix ensured summarised statistical information together with a deeper understanding of underlying meanings behind responses.

2.5.1. Quantitative Analysis

Data cleansing ensured accuracy, and subsequent descriptive and inferential statistics were undertaken to identify patterns and relationships indicating support needs and barriers (further information is available upon request).

2.5.2. Qualitative Analysis

Focus group and interview data were transcribed, and together with the qualitative survey data were coded and analysed using Reflexive Thematic Analysis (Braun & Clark, 2022). This involved extensive and reflective reading of responses, before inductive coding as informed by the research questions, the research team's knowledge and expertise, and insights from participants themselves. Codes were then grouped around a central topic, into overall themes. For example, the code 'having a voice' was merged with other codes (such as 'lack of knowledge') into an overall theme of 'support needs'. The research team compiled a codebook 'template' as a tool to enable a structured approach to coding and theme development, providing insight and symmetry throughout (Braun & Clarke, 2022; King, 2012). Theoretically the research used a constructionism framework (meaning making from the data) and utilised pragmatism as the ontological approach to ensure methods aligned with research questions.

3. Results

Section 3.1 clarifies participant data for each method independently. Thereafter overall themes from all data are discussed holistically. Unless specified, findings are from the survey; results from the focus group or interviews are referred to explicitly where used.

3.1. Participant Information

3.1.1. Survey

A total of 317 people completed the survey, 212 from the Southampton area (UK). The age range of respondents was 16-83 years. Nearly 75% were British, and 10% identified as an ethnic minority with a wide range of nationalities represented. Over 77% identified as female, nearly 70% of those identified as heterosexual and 20% as bisexual. Fifty four percent of the sample considered themselves a disabled person; of these 170 individuals, the most cited disability was 'mental illness/nervous disorder' (87%) with mobility impairment (28%) and Autism (27%) also common. As such the respondents were representative of our target population. The findings indicated some people may not identify with certain groups (e.g. a disabled person may not feel they belong to the disabled community) and intersectionality was acknowledged in the data – i.e. some people belonged to more than one group (e.g. were BME and disabled).

Seventy percent of respondents had accessed some support from DA services - for 63% this was in relation to their own needs. Of those, 64% LGBTQIA+, 12.2% BME and 56.6 disabled people had used DA services. Over half of participants accessed counselling services; 40% mental health support; and 34% had sought support regarding how to leave their partner or report an offence.

3.1.2. Focus Group

Two participants attended the focus group. Both worked in the same local authority but in different roles; one ("Fay") as an Independent Domestic Violence Adviser providing emotional and practical support for victim/survivors; and the other ("Louise") worked in housing.

3.1.3. Interviews

Two victim/survivors agreed to be interviewed - one BME (non-disabled) and one BME and disabled ("Maya" and "Rhea"). Both identified as heterosexual.

3.2. Identified Themes

3.2.1. Good Practice

Of those who had utilised support, over two-thirds stated it was either partially or very useful, particularly in relation to emotional and non-judgemental support. From the qualitative comments, quotes indicated how 'lifesaving' the assistance was:

"Without their support I would not have been able to leave and I would likely not be alive" (Fleur, European)

Findings from the focus group recognised extended areas of support from family, communities and religious groups. They highlighted increased efforts to work collaboratively with other agencies, to address perpetrator behaviour (through criminal justice and intervention programmes) and support service users in their own homes:

"I think one of the shifts … to attempt as much as possible to keep people in their own home, that managing a move is not necessarily the best option" (Fay)

Interview findings highlighted good practice by certain individuals in the police (e.g. giving advice), social work (taking allegations seriously), at court (e.g. a judge taking children into chambers) and by support agencies (them listening, understanding, providing courses). Maya highlighted how having a support worker with a similar Muslim background assisted her:

"I don't have to mention to her, she already knows things… she also gave me a number for one of the Imam… even helped me with what sort of questions that I should be asking… That was that was really good" (Maya)

3.2.2. Secondary Victimisation

As well as positive experiences, some respondents described being re-victimised by agencies, services and individuals they initially anticipated would support them, leaving them feeling let down:

"I was told by NHS officially: The abuse is too vile for them to handle" (Maria, Black British, heterosexual, non-disabled)

"I was not listened to… I was asked in front of my abuser every time to talk about what was happening" (Francis, White British, heterosexual, non-disabled)

Both interviewees described similar poor or unexpected responses from agencies, sometimes making the situation worse:

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

"They [police] said it's a civil matter. But there's violence involved… they could have nipped in the bud they could have stopped all this" (Rhea)

A lack of community knowledge was also mentioned:

"when ladies go into toilet have something on their hand to say help… didn't work. A lot of people didn't even know what it meant" (Rhea)

Even refuges made things difficult, enhancing barriers to recovery:

"I was bleeding… got no help… they said… you have to walk to the doctor which is so far away. I had no pushchair… I wasn't allowed to call a taxi… can somebody get my car?... No, you're not allowed to… they're not making this any easier" (Rhea)

3.2.3. Barriers to Obtaining Support

Just over half (n=160) of respondents stated barriers reduced their access to support. The most frequent barriers included embarrassment or shame (68%), not recognising the abuse (67%), fear of what might happen (66%), or of not being believed (63%) as outlined in Table 1.

Table 1. Barriers to accessing support.

Barriers to accessing support	**No. of Yes Responses (n=160)**	**Percentage (%) *(Rounded)***
Embarrassment or shame	109	68
Not recognising abuse	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
Accessing support	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

Findings were largely similar for specific communities, however, people who identified as BME scored higher than average on fear of what might happen, denial and hoping things would change. Free-text survey answers also highlighted emotional barriers of self-blame and shame:

"I thought it was my fault" (Nancy, Mixed British, heterosexual, non-disabled)

"I might be making a big deal and bringing shame" (Faiza, British Asian, heterosexual, non-disabled)

These were often related to lack of recognition or 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 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)

For disabled people and the LGBTQIA+ community, the highest score was fear of not being believed:

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

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

Views of others, or constraints faced by professionals made experiences worse. If abusers portray themselves as charming, it may appear the victim/survivor is to blame, reflecting the 'gaslighting' experienced by some:

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

This layering of experiences, from lack of recognition or self-belief (compounded by gaslighting), fear of reprisals or not being believed, has a significant impact on victim/survivor's ability to seek help. Other barriers included worry about children or finances:

"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 couldn't afford to leave my ex…. Where would I go? The children were being manipulated … and I wasn't prepared to leave them where this misinformation could continue" (Elsie, White British, heterosexual, non-disabled)

Others discussed isolation, with practical considerations exacerbated by cultural expectations/difficulties:

"I hesitated to admit or seek support as I'm an Asian so I had a lot to lose in society and community" (Amala, British Bangladeshi, heterosexual, non-disabled)

"As an immigrant I could not report early because I could not speak well," (Beatriz, Chilean, heterosexual, non-disabled)

The focus group identified similar barriers:

"just trying to find an interpreter can take a very long time" (Louise)

For disabled respondents, accessibility and being cared for by their abusers were also significant barriers:

"it was hard to get there, being a wheelchair user" (Evie, White British, heterosexual, disabled)

"with physical disabilities… I relied on him for support, physically, mentally and financially" (Rosie, White British, heterosexual, disabled)

Therefore individual barriers can be compounded by organisational barriers. Many highlighted not knowing what DA includes, nor what support was available:

"I didn't know where to go or who to talk to" (Olivia, White British, heterosexual, disabled)

Some sourced support through media or agencies, but many desired increased awareness and promotions in educational and healthcare settings, online, via media, posters and in different languages. Another repeated message from both the interviews and surveys was respondents feeling they were directed from one service to another:

"I don't want to see 10 different people" (Rhea)

"I got passed around, had to retell different people my story over again in a bid to get help, and it's embarrassing ... I have seriously struggled to get the help I need" (Violet, White British, heterosexual, non-disabled)

This further example of secondary victimisation caused confusion:

"I feel like I am walking in a maze" (Valerie, White British, heterosexual, disabled)

"I sometimes wonder if it would have been easier to stay" (Claudia, White British, heterosexual, non-disabled)

A coordinated approach with a central hub was advocated:

"Too many satellite agencies and resources… how is a victim meant to know… which is the best one to turn to? Needs a nationally recognised and well publicised umbrella 'face' so that any person… knows exactly

where to turn… an online triage process… who can help and a handholding online 'advocate'" (Phoebe, White English, heterosexual, non-disabled)

Also related to access, numerous respondents highlighted long wait times (between 2-3 years), stating they needed services sooner as delays had severe consequences:

"I had a lot of low days while waiting, including thinking of taking the abuser back" (Nihal, Sri Lankan, heterosexual, non-disabled)

"I wanted to end my life…the service isn't helping people" (Violet, White British, straight, disabled)

Many respondents also wanted sessions more frequently and to utilise them for longer:

"At least once a week" (Isabel, White British, heterosexual, disabled)

"12 or 14 or 16 [sessions] most definitely are not… enough" (Enid, White British, heterosexual, disabled)

A lack of follow-up support was also evidenced, with some describing a 'drop off' at the end of support, and its emotional impact:

"after a few months, it suddenly disappears and you are left alone in the ruins of your life" (Evelyn, White British, bisexual, disabled)

"I was not given any instructions on what to do next" (Helvi, African, lesbian, non-disabled)

One respondent suggested introducing a

"care plan after… to prevent them returning to their abuser" (Charlotte, White British, bisexual, disabled).

Other comments related to availability of services in their locality at relevant times, as services are not always available outside 'working hours'. Participants recognised this was down to a lack of resources:

"Too long waiting list because it's severely underfunded" (Rosemary, White British, heterosexual, non-disabled)

Worryingly, self-sacrifice was evident as participants discussed not wanting to be a burden on services. They were conscious there is not enough supply to meet demand which can put individuals at risk if they do not access help when required.

Barriers highlighted in the focus group also included high demand for services – necessitating prioritisation of only those at highest risk; frustrated further by a lack of housing stock – particularly for transgender and/or disabled people; 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'.. we are putting a bucket underneath the hole… catching as many as we can… trying to stop the place from flooding" (Louise)

In summary there are significant barriers hindering victim/survivors getting support which appear more acute for certain groups. Whilst personal and emotional barriers may be more difficult to address; organisational barriers, such as making services accessible at the point of need and offering support for as long as required, necessitates adequate resource and further consideration of support needs of clients.

3.2.4. Support Needs – General

When asked what support respondents wanted, the most frequently reported services requested were access to mental health support and one to one counselling, followed by advice regarding how to remain safe, and advocacy. In free-text answers, respondents expressed a strong desire for greater service provision including more outdoor activities, peer support groups, and online resources. They stated the benefits of connecting remotely:

"I did mine online video call I was in the comfort of my home" (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)

On interviewee highlighted:

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

The need for support tailored to individual needs was seen as important:

"they offered to find ways for me to be more comfortable and safe… drawing or listening to background music while we talked" (Isabel, White British, heterosexual, disabled)

Other pragmatic suggestions for professionals included:

"Don't use long words, or words shortened like DA … people in a distressed state struggle to process things anyway without jargon"(Iris, White British, straight, non-disabled)

"An appointed advocate for each victim… would be hugely, hugely beneficial… we are already overwhelmed by just trying to survive" (Phoebe, White English, heterosexual, non-disabled)

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

There were also other important factors for accessing support reflected in both the survey and interviews such as the need for confidentiality, to feel supported and be heard:

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

"I was being heard" (Maya)

Both interviewees highlighted this was a novel situation for them and they wanted to feel that professionals fufilled basic needs:

"Why wasn't there a [police] officer that had more understanding… had no idea and very, like… what's happened tell us? There was no empathy… nothing to say… you're protected… he cannot come back… you're not alone… we're here to help" (Rhea)

"I didn't even have a phone to use" (Rhea)

This was particularly pertinent in relation to accommodation - one survey participant was offered a refuge place, but had to leave her male teenage child behind to access it. This was also reflected in the interviews:

"My solicitor says to me, the best thing to do is look for a flat… how am I going to afford this? … they found this really horrible place… My kids will never come… no TV… so cold… my dad bought food… some duvets and blow up mattresses" (Rhea)

In summary, there are patterns in general needs of victim/survivors, but also individual differences and preferences for types help and forms of support. Such individualised needs can be even more acute when bespoke needs of specific communities are considered.

3.2.5. Support Needs – Bespoke

3.2.5.1. BME

Eighty percent of the survey respondents who identified as BME believed they have specific needs for support. One BME woman described how being moved to a refuge in a predominantly 'White' area left her feeling 'out of place'. Linked to barriers outlined above, respondents identified different cultural expectations can mean individuals might be less likely to seek help:

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

Proactive suggestions included:

"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)

3.2.5.2. Disabled People

Disabled (58%) respondents felt disabled people have specific support needs from DA services. Free-text comments included ensuring appropriate communication aids, producing easy read versions of resources, and ensuring accessible and suitable accommodation. Significant numbers of respondents reported increased difficulty accessing services due to a variety of mental and/or physical health conditions. Particularly as:

"mental illness can 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… quiet, self contained, private places people can stay… Autistic people can't be expected to live in ordinary shelters… it's such a strain on an already overwhelmed sensory system" (Ella, White British, bisexual, disabled)

3.2.5.3. LGBTQIA+

Individuals of all types of sexual orientation believed LGBTQIA+ individuals have specific support needs, recognising specific challenges including discrimination, increased isolation, or relationship dynamics which may make abuse harder to identify and seek help. For example:

"they would have had a different experience of abuse as it is a different kind of relationship" (Ellie, British French, bisexual, non-disabled)

"I think in same sex relationships it can be quite difficult as… this might affect traditional gender roles/identity such as male on male violence" (Freya, White British, heterosexual, disabled)

Again, services provided by those within, or at least with a good knowledge of experiences communities may encounter, was highlighted repeatedly:

"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 appears to reduce the need for the victim/survivor to have to explain everything, reducing their distress, and enhancing their feeling understood and supported.

These themes are summarised in Figure 1.

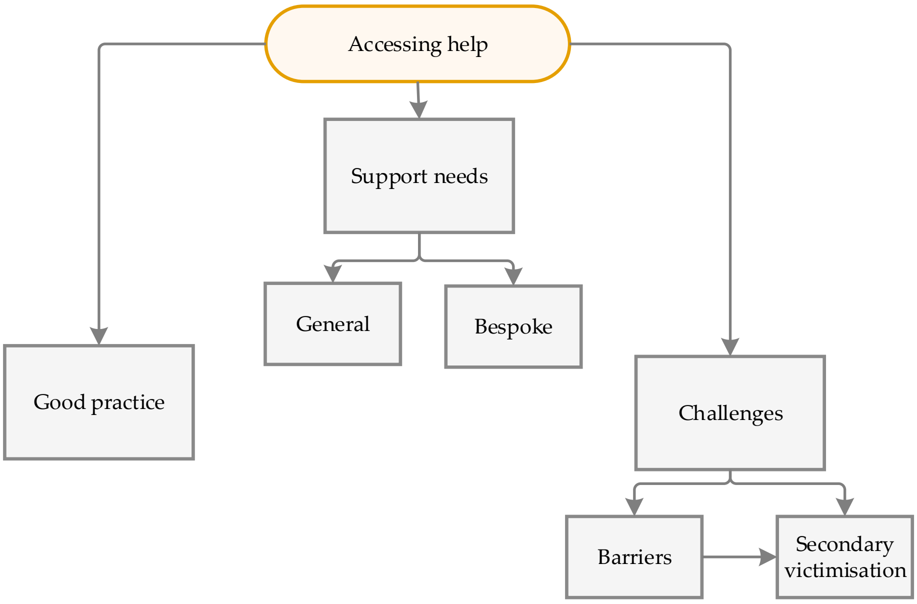

Figure 1. Summary of themes.

The findings from the surveys, focus group and interviews identified several consistent themes. Despite years of research, knowledge and practice, there are still many difficulties in victim/survivors' accessing help for IPVA. These can be individual – for example from personal embarrassment or shame; or resulting from more organizational issues such as limited resources and limiting access. Yet there are patterns in the needs identified by victim/survivors with many highlighting similarities in what they require. However, some communities appear to have bespoke needs – such as ensuring appropriate access for disabled people. Whilst some good practice by various support agencies have been identified, it is alarming to note that many challenges remain. There are significant barriers to individuals obtaining help, and secondary victimization is evident, despite improvements to training and awareness.

doi:10.20944/preprints202411.2348.v1

4. Discussion

Interpreting the results in relation to the original research questions posed, firstly, in terms of consideration of what support services are currently doing well, the findings demonstrate how service providers are offering many of the services victim/survivors need, are held in high regard, and are providing tailored services for some. Services are deemed not only useful, but for many essential for survival, wellbeing and recovery. As such DA support services need to continue. Secondly, in consideration of what could be improved, many expressed a desire for recognition of their abuse, and that gaining access to services was difficult due to delays or being passed around different services. Additionally, there is evident demand for increased knowledge and promotion of what constitutes DA, what services are currently available in the community, and the provision of a centralised triage to direct victim/survivors, providing standardisation and clarity to victim/survivor experiences. Resourcing, in particular lengthy waiting lists, limited access to appropriate housing and basic considerations such as access to interpreters, acted as significant barriers to gaining support. Ideally optionality of service provision, such as out of hours or online support, with availability for longer periods, alongside an ongoing care plan, would be available for all at the point of need.

Poor practice by a variety of agencies was noted, some with significant negative impacts resulting in secondary victimisation, as victim/survivors described being let down, necessitating the need for even greater support. This reflects previous findings by Bostock et al. (2009) which highlighted how service responses to victims/survivors could reinforce the abuse if it was not done with care. The need for enhanced knowledge, training and basic empathy when dealing with victim/survivors, recognising this is their lives, is necessary for all providers who come into contact with DA victim/survivors. Multidisciplinary training initiatives should incorporate awareness and understanding of competing challenges in order to co-create pragmatic and workable solutions. In terms of future resourcing, enhancing timely access to services, and promoting awareness to the general public of what constitutes DA/IPVA, is also a significant need.

Specifically, when considering LBGTQIA+, BME and disabled people, overwhelmingly most participants noted the bespoke needs of these 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 possess, and as such is strongly recommended in order to offer fully inclusive, empathic services which reduces, rather than adds to, the trauma and difficulties encountered. Further research into other groups with bespoke needs – for example men – to ascertain what and why bespoke services may be required and the benefits of these would be worthwhile.

What is clearly evident from the findings of this study is that some barriers identified almost 20 years ago by Fugate et al. (2005) continue today: for example, knowledge of services, fear, need for confidentiality, shame, and fear of being judged. The barriers found in the BME group echo those found in previous studies around cultural barriers and cultural competence (Hulley et al., 2023), although interestingly the issue of institutional racism was not raised in the present findings. However, in line with Hulley et al.'s (2023) study, the barriers were weaponised by perpetrators, for example perpetrators 'selling the idea' that the woman was experiencing mental health issues which further isolated the victim/survivors. Our findings also echo those of Scheer et al. (2023) who found similarly that their sample did not seek help because they did not want to contribute to the negative perceptions of the LGBTQIA+ community.

Participants had very clear ideas about the type of support needed; it should be long term with ongoing, follow up contact to deal with the effects of long-term trauma. This aligns with organisations and practitioners taking a trauma-informed approach to their work when working with victim/survivors of IPVA (Ferrari et al., 2016), including long-term support after a programme ends (Wilson et al., 2015). Another key element of the trauma informed approach is the need for 'cultural competence' (Wilson et al., 2015) and understanding of bespoke needs, which also fits with the feedback from participants. BME individuals may have language difficulties or abuse may be normalised within their family/culture. Disabled people may have additional difficulties accessing services, or may be reliant upon their abuser for day to day care which can significantly both increase the risk of reaching out for support and also limit access to support. LGBTQIA+ may suffer from stereotypes regarding such relationships or have more limited support. Moreover, such an approach would also recognise that as a result of living with a person who systematically physically and/or emotionally abusive, our evidence suggests victim/survivors are likely to experience poor mental health, and so lines between cause and effect may become blurred.

Our study has highlighted the importance of listening to the voice of the service users, recognising how people with lived experience are the 'experts' and therefore their suggestions for services should be sought and listened to. We advocate further research in this regard; exploring solutions 'with', rather than researching 'to' or 'for' them. It is also important to recognise the impact is broader than upon the victim/survivor – children, family and wider friendship groups can all be caught in the web of DA, and future research considering their experiences would be worthwhile.

With so much evidence clearly identifying barriers for support and also relatively straight forward solutions, we are left with the question: why is nothing really changing? This is a particularly pertinent question in the UK as coercive control was recognised as a crime in 2015 and the recognition of the harm to children in the Domestic Abuse Act 2021. An obvious answer here are finite resources. However, given the harm that domestic abuse does not just to the victim, but also children and potentially the wider family and community, focussing limited resources into victim services is short sighted. Enhancements to funding perpetrator programmes can help change behaviour, and considering how society as a whole contributes with socially dominant narratives around gender and 'minority groups' (which may in itself be a misnomer as the majority of people will fall into some category or another at some time) is required. Reducing the widespread nature of domestic abuse is a national priority (Home Office, 2024) but victim/survivors from minority communities can lose out when budgets are stretched and finite. Mminority groups are no less deserving of living abuse free lives but are sometimes less heard. It is essential all voices are both heard *and* responded to.

Author Contributions: All authors contributed to conceptualization, methodology, data collection, analysis, writing—review and editing. Terri Cole was responsible for supervision and secured funding. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by Yellow Door and Stop Domestic Abuse on behalf of Southampton City Council who commissioned specialist advocacy services for bespoke groups of victim/survivors of domestic abuse.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Supporting information regarding data is available upon request.

Acknowledgments: 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 victim/survivors who answered the survey and took part in interviews, and the professionals who took part in the focus group.

Conflicts of Interest: The authors declare no conflicts of interest. The funders agreed the design of the study; and assisted in sharing the link to the survey and in identifying potential participants in the focus group and interviews. The funders had no role in the analyses, interpretation of data; or in the writing of this manuscript; but have agreed to publication of the results.

References

Ablaza, C., Kuskoff, E., Perales, F., & Parsell, C. (2022). Responding to Domestic and Family Violence: The Role of Non-Specialist Services and Implications for Social Work. *The British Journal of Social Work*, 81–99. https://doi.org/10.1093/bjsw/bcac125

Afe, T. O., Emedoh, T. C., Ogunsemi, O. O., & Adegohun, A. A. (2017). Socio-Demographic Characteristics, Partner Characteristics, Socioeconomic Variables, and Intimate Partner Violence in Women with Schizophrenia in South-South Nigeria. *Journal of Health Care for the Poor and Underserved*, *28*(2), 707– 720. https://doi.org/10.1353/hpu.2017.0069

Afrouz, R., Crisp, B. R. &Taket, A. (2020). Seeking Help in Domestic Violence Among Muslim Women in Muslim-Majority and Non-Muslim-Majority Countries. *Trauma, Violence & Abuse*, 21(3), 551-566.

Ammar, N., Couture-Carron, A., Alvi, S. & San Antonio, J. (2014). Experiences of Muslim and Non-Muslim Battered Immigrant Women With the Police in the United States: A Closer Understanding of Commonalities and Differences. *Violence Against Women*, 19(12), 1449-1471

Andersson, N., Cockroft, A., Ansari, U., Omar, K., Ansari, N. M., Khan, A. & Chaudhry, U.U. (2009). Barriers to Disclosing and Reporting Violence Among Women in Pakistan: Findings From a National Household Survey and Focus Group Discussions. *Journal of Interpersonal Violence*, 25(11), 1965-1985

Anitha, S. (2008). Neither safety nor justice: The UK government response to domestic violence against immigrant women. *Journal of Social Welfare and Family Law, 30*(3), 189–202. https://doi.org/10.1080/09649060802550592AVA, 2022

AVA. (2022). *Staying Mum A review of the literature on domestic abuse, mothering and child removal*.

Balderston, S. (2013) Victimized again? Intersectionality and injustice in disabled women's lives after hate crime and rape. In Texler Segal, M. & Demos, V. eds. *Gendered Perspectives on Conflict and Violence*: Part A (Advances in Gender Research, Volume 18A) Emerald Group Publishing Limited, pp.17 - 51

Bostock, J., Plumpton, M., & Pratt, Re. (2009). Domestic Violence Against Women: Understanding Social Processes and Women's Experiences. *Journal of Community & Applied Social Psychology, 19*, 95–110. https://doi.org/10.1002/casp.985

Braun, V. and Clarke, V. 2022. *Thematic Analysis: A Practical Guide.* Sage: London CDC, 2013

Coles, N., Stokes, N., Retter, E., Manning, F., Curno, O., & Awoonor-Gordon, G. (n.d.). *Blind and partially sighted people's experiences of domestic abuse*

Couto, L, O'Leary, N & Brennan< I (2023) Police victims of domestic abuse: barriers to reporting victimisation, *Policing and Society*, DOI: 10.1080/10439463.2023.2250523 48

Domestic Abuse Act (2021) Domestic Abuse Act 2021

Ellsberg M, Jansen HAFM, Heise L, et al. (2008) Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet.* 371(9619):1165–72. 10.1016/S0140-6736(08)60522-X

Emerson, E., & Llewellyn, G. (2023). Exposure of women with and without disabilities to violence and discrimination: evidence from cross-sectional national surveys in 29 middle-and low-income countries. *Journal of interpersonal violence*, *38*(11-12), 7215-7241.

Equality Act (2010) Equality Act 2010

Fanslow, J. L., Malihi, Z. A., Hashemi, L., Gulliver, P. J., & McIntosh, T. K. D. (2021). Lifetime Prevalence of Intimate Partner Violence and Disability: Results From a Population-Based Study in *New Zealand. American Journal of Preventive Medicine, 61*(3), 320–328. https://doi.org/10.1016/j.amepre.2021.02.022

Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T. J., Sardinha, L., & Feder, G. S. (2016). Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. *Global Health Action*, *9*(1), 1–11. https://doi.org/10.3402/gha.v9.29890

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking: Implications for intervention. *Violence Against Women*, *11*(3), 290–310. https://doi.org/10.1177/1077801204271959

Graca, S. (2017) Domestic violence policy and legislation in the UK: A discussion of immigrant women's vulnerabilities. *Eur. J. Curr. Leg. Issues, 22*, 1–34.

Griffiths, S., Allison, C., Kenny, R., Holt, R., Smith, P., & Baron-Cohen, S. (2019). The Vulnerability Experiences Quotient (VEQ): A Study of Vulnerability, Mental Health and Life Satisfaction in Autistic Adults. *Autism Research, 12*(10), 1516–1528. https://doi.org/10.1002/aur.2162

Guasp, A. (2011). *Lesbian, gay & bisexual people in later life*. London: Stonewall.

Hassouneh, D., & Glass, N. (2008). The Influence of Gender Role Stereotyping on Women's Experiences of Female Same-Sex Intimate Partner Violence. Violence Against Women, 14(3), 310–325. https://doi.org/10.1177/1077801207313734

Healy, J.C. (2021) 'An exposition of sexual violence as a method of disablist hate crime', in I. Zempi and J. Smith (eds.) *Misogyny as Hate Crime*. London: Routledge, pp. 178-194

Heron, R. L., Eisma, M. C., & Browne, K. (2022). Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service. *Journal of Family Violence*, *37*(3), 533–543. https://doi.org/10.1007/s10896-020-00236-3

Home Office (2024) *New measures set out to combat violence against women and girls.* 19 September 2024, from https://www.gov.uk/government/news/new-measures-set-out-to-combat-violence-against-women-and-girls

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L. McCoy, E., Mikton, C., Shakespeare, T. & Officer, A. (2012) Prevalence and risk of violence against adults with disabilities: A systematic review and metaanalysis of observational studies. *The Lancet, 379*(9826), pp.1621-16

Hulley, J., Bailey, L., Kirkman, G., Gibbs, G. R., Gomersall, T., Latif, A., & Jones, A. (2023). Intimate Partner Violence and Barriers to Help-Seeking Among Black, Asian, Minority Ethnic and Immigrant Women: A Qualitative Metasynthesis of Global Research. *Trauma, Violence, and Abuse*, *24*(2), 1001–1015. https://doi.org/10.1177/15248380211050590

Interventions Alliance. (n.d.). *Domestic Abuse in Black, Asian and Minority Ethnic Groups | Interventions Alliance*. Retrieved December 20, 2023, from https://interventionsalliance.com/domestic-abuse-in-black-asianand-minority-ethnic-groups/

Iob, E., Steptoe, A., & Fancourt, D. (2020). Abuse, self-harm and suicidal ideation in the UK during the COVID19 pandemic. *British Journal of Psychiatry, 217*(4), 543–546. https://doi.org/10.1192/bjp.2020.130

Johnston-McCabe, P., Levi-Minzi, M., Van Hasselt, V. B., & Vanderbeek, A. (2011). Domestic Violence and Social Support in a Clinical Sample of Deaf and Hard of Hearing Women. *Journal of Family Violence, 26*(1), 63– 69. https://doi.org/10.1007/s10896-010-9342-4

Kubicek, K., McNeeley, M., & Collins, S. (2016). Young Men Who Have Sex With Men's Experiences With Intimate Partner Violence. *Journal of Adolescent Research, 31*(2), 143–175. https://doi.org/10.1177/0743558415584011

McDowell, M. J., Hughto, J. M., & Reisner, S. L. (2019). Risk and protective factors for mental health morbidity in a community sample of female-to-male trans-masculine adults. *BMC psychiatry*, *19*, 1-12.

Magowan, P. (2003) Nowhere to run, nowhere to hide: domestic violence and disabled women. *Safe: Domestic Abuse Quarterly 5*, pp.15-18

Maxwell, S. O'Brien, R. & Stenhouse, R. (2022). *Experiences of Scottish Men who have been subject to Intimate Partner Violence in Same Sex Relationships* Research Report *GBM_RR_summary.pdf (waverleycare.org) New Jersey Institute of Technology, 2022

Olabanji, O. A. (2022). Collaborative Approaches to Addressing Domestic and Sexual Violence among Black and Minority Ethnic Communities in Southampton: A Case Study of Yellow Door. *Societies*, *12*(6). https://doi.org/10.3390/soc12060165

Office of National Statistics. (2022). Characteristics of victims of domestic abuse based on findings from the *Crime Survey for England and Wales* and police recorded crime.

Office for National Statistics (ONS), (2023) *Domestic abuse victim characteristics, England and Wales*: year ending March 2023

Peitzmeier, S. M., Malik, M., Kattari, S. K., Marrow, E., Stephenson, R., Agénor, M., & Reisner, S. L. (2020). Intimate partner violence in transgender populations: Systematic review and meta-analysis of prevalence and correlates. In *American Journal of Public Health (Vol. 110*, Issue 9, pp. E1–E14). American Public Health Association Inc. https://doi.org/10.2105/AJPH.2020.305774

Pettitt, B., Greenhead, S., Khalifeh, H., Drennan, V., Hart, T., Hogg, J., Borschmann, R., Mamo, E. & Moran, P. (2013) *At risk, yet dismissed: The criminal victimisation of people with mental health problems*. London: Victim Support & Mind

Romero-Sánchez, M., Skowronski, M., Bohner, G., & Megías, J. L. (2021). Talking about 'victims', 'survivors' and 'battered women': how labels affect the perception of women who have experienced intimate partner violence. *Revista de Psicologia Social*, *36*(1), 30–60. https://doi.org/10.1080/02134748.2020.1840232

SafeLives (2015) Getting it right the first time - SafeLives

SafeLives. (2017b). *Your Choice: 'honour'-based violence, forced marriage and domestic abuse*.

Scheer, J. R., Lawlace, M., Cascalheira, C. J., Newcomb, M. E., & Whitton, S. W. (2023). Help-Seeking for Severe Intimate Partner Violence Among Sexual and Gender Minority Adolescents and Young Adults Assigned Female at birth: A Latent Class Analysis. *Journal of Interpersonal Violence*, *38*(9–10), 6723–6750. https://doi.org/10.1177/08862605221137711

Sin, C. H. (2015) Hate crime against people with disabilities. In Hall, N., Corb, A., Giannasi, P. & Grieve, J.G.D. ed(s) *The Routledge International Handbook on Hate Crime*. Oxon: Routledge, pp.193-206

Stephenson, R., Darbes, L. A., Rosso, M. T., Washington, C., Hightow-Weidman, L., Sullivan, P., & Gamarel, K. E. (2022). Perceptions of Contexts of Intimate Partner Violence Among Young, Partnered Gay, Bisexual and Other Men Who Have Sex With Men in the United States. *Journal of Interpersonal Violence, 37*(15– 16), NP12881–NP12900. https://doi.org/10.1177/08862605211001472

Thiara, R. K. & Hague, G. (2013) Disabled women and domestic violence: Increased risk but fewer services. In Roulstone, A. & Mason-Bish, H. ed(s). *Disability, Hate Crime and Violence*. London: Routledge, pp106- 117

WHO (2018) Violence against women Prevalence Estimates, 2018. Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. WHO: Geneva, 2021

Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry*, *85*(6), 586–599. https://doi.org/10.1037/ort0000098