

Services for domestic violence victims in the U.K. and United States:

Where are we today?

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### Abstract

Over the last 50 years, there has developed a wealth of literature that has explored the experiences of victims of intimate partner violence (IPV). This has demonstrated the adverse impact IPV has, including the impact on both female (e.g., Sarkar, 2008), and male victims (e.g., Próspero, 2007) and those within the LGBTQ+ community (e.g., Reuter et al., 2018). Over these 50 years, there has also been the development of key legislation, policy, and services to support these victims and reduce the prevalence of IPV. A comprehensive review of victim services was provided by Eckhardt and colleagues in 2013 (Eckhardt et al., 2013) as part of the Partner Abuse State of Knowledge project. The aim of the current paper is to expand on and update this review with an international focus, drawing on both the United Kingdom (UK) and United States of America (US). Specifically, we discuss current legislation and policy and how this informs practice, what services and resources are available for victims in the two countries, and what interventions are available and what we know of their effectiveness. A final aim is to explore one of Eckhardt et al.'s specific recommendations about what exists to support “underserved” populations, such as men and those in the LGBTQ+ community.

**Keywords:** domestic violence, intimate partner violence, victim services, underserved

According to the World Health Organization (2012), intimate partner violence (IPV), refers to any behaviour in an intimate relationship that causes psychological, physical, or sexual harm to the individuals engaged in the relationship. This can include belittling, intimidating, humiliating, or controlling a partner; pushing, shoving, slapping, or beating a partner; and finally, coerced or forced sexual activity. Many IPV victims seek help from either formal or informal sources of support (Cho et al., 2017). Formal sources of support include DV agencies or helplines, police, medical, or mental health providers. Informal sources of support include family, friends, and online resources. In 2018 in England and Wales, 73.5% of women and 43.7% of men told someone they knew personally, 33.4% of women and 26.1% of men told someone official (e.g., police, health professional), and 34.2% of women and 24.1% of men told another support professional (e.g., counsellor, helpline, victim support; ONS, 2019). Estimates from the U.S. in 2010 show that roughly 90% of victims seek formal or informal help (Cho et al., 2017). Similar to the UK, women sought more help. Additionally, victims who experience multiple forms of IPV or who experience physical, as opposed to just psychological aggression, are more likely to seek formal support (D’Inverno et al., 2019; Cho et al., 2017). The services that victims seek and receive are the focus of this paper.

A comprehensive review of victim services was provided by Eckhardt and colleagues in 2013 (Eckhardt et al., 2013). This paper will expand and update that review. We aim to explore broadly what interventions and services are currently available for IPV victims with an international perspective and comparison between the United Kingdom (UK) and the United States (US). Specifically, we discuss: a) current policy and how this informs practice, b) what resources and organisations are supporting victims, c) what interventions are available and what is known of their effectiveness, d) what exists to support “underserved” populations, such as men

and those in LGBTQ+ community. Whilst this is not exhaustive and we cannot cover everything, this represents a comprehensive review. This paper culminates in a series of recommendations about future research and practice. On a final note, IPV is referred to using multiple terms, including as intimate partner abuse (IPA) and domestic violence (DV) and we use these terms interchangeably.

### **Summary of the Eckhardt Review**

The 17 literature reviews of the Partner Abuse State of Knowledge Project, published in several consecutive issues of the journal in 2012-2013 and available at [www.domesticviolenceresearch.org](http://www.domesticviolenceresearch.org), engaged over 60 qualified authors who reviewed and synthesized over 1,700 research articles on IPV (Hamel, Langhinrichsen-Rohling, & Hines, 2012). One element of this project was a section which focused on IPV services. Eckhardt et al. (2013) published a review that explored the use of intervention programs for both perpetrators and victims of intimate partner violence (IPV). They found that there were effective therapeutic approaches seen within the literature, with Cognitive Behavioral Therapy (CBT) having the strongest effects. Their review also showed some efficacy for community-based advocacy support and other brief interventions, but the evidence was more mixed, which prevented them from drawing firm conclusions about the long-term effectiveness of these approaches. These interventions seem to be more effective in terms of reducing the adverse outcomes associated with abuse (e.g., Post Traumatic Stress Disorder [PTSD] symptoms), compared to those aiming to reduce IPV victimization. Outcomes concerning the effectiveness of programs intended to reduce IPV victimization were inconsistent and did not appear to reduce risk for revictimization.

Eckhardt et al. (2013) identified a number of limitations with the existing literature exploring victim interventions, including insufficient long-term follow up periods, a lack of

research exploring the victim's own use of aggression (which has implications for both risk and the possibility of revictimization), and a lack of research exploring interventions for male victims, with female perpetrator samples, thus reducing the understanding of how these interventions have an impact on the broader range of victim groups. One aim of the current paper is to explore whether there have been any developments in these services and interventions, and in the research evaluating them since the review conducted by Eckhardt and colleagues.

## **Legislation and Policy**

### United Kingdom

Across the UK, each devolved government has powers to make changes within its own legislation. Within the England and Wales, IPV is prosecuted under the Violence Against Women and Girls (VAWG) strategy. The Crown Prosecution Service (CPS; see Crown Prosecution Service, 2019) guidance states that “VAWG crimes describes behaviours which are committed primarily, although not exclusively, by men against women” and “recognises that victims of VAWG crimes are disproportionately women with the majority of perpetrators being male.” It includes IPV and abuse as well as a range of other offenses including, but not limited to, rape and sexual violence, stalking, forced marriage and child sex abuse.

This gendered strategy and approach does not have full support from all within the sector, however especially from charities that support male victims as they argue that it minimises and further marginalises them, arguing that there should be parallel strategy for male victims of these crimes (see for example, Mankind Initiative, 2017). In recognition of the barriers that male

victims face and the impact of this gendered strategy, both the Crown Prosecution Service and the UK Home Office issues released statements in reference to male victims.

In recognition of the barriers that male victims face and the impact of this gendered strategy, both the Crown Prosecution Service (CPS) and the UK Home Office issues released statements in reference to male victims. The CPS (2017) statement reaffirms its commitment to supporting male victims of IPV through a number of mechanisms including: challenging current myths or stereotypes about IPV, ensuring that training and guidance materials have male victims' examples included, reflecting men's experiences within media and campaigns to increase men's reporting. They recognise that men may experience gender-specific types of abuse and specific barriers that may prevent their reporting. The Home Office (2019) position statement reaffirms some of this; it discusses the prevalence of men's victimisation, barriers to accessing support, It lists 12 commitments which include funding specialist support organisations for male victims and LGBT organisations, ensuring communication and campaigns are gender inclusive, and working with the CPS to better understand the data on gender of victims and perpetrators to better understand the trends seen.

In recognising the impact, cost, and consequences of domestic violence and abuse, the UK Government has proposed a new approach to ensure this issue is tackled in a focused, holistic, and transformative way. The precedent for gendered legislation was set with the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015); this was the first legislative act within the UK to focus on domestic violence with a specific emphasis on "prevention, protection and support." The new Domestic Abuse Bill which applies in England and Wales (expected to be passed in Parliament in 2020, see Home Office Domestic Abuse Bill, 2020) proposes a gender-neutral statutory definition of domestic violence and abuse that captures

physical and non-physical abuse (e.g. economic, psychological/emotional, coercive control).

This definition is gender neutral and inclusive as UK law has to be able to be applied to all citizens equally (and has since 1215) and also has to comply with the Human Right's legislation.

However, in the reading of the new Bill, many have been critical of a proposed clause which states "Any guidance issued under this section must, so far as relevant, take account of the fact that the majority of victims of domestic abuse in England and Wales are female". However, some organisations and charities argue that this will marginalise male and LGBTQ+ victims as this clause means those using the guidance in practice will be steered to give priority to female victims (see ManKind Initiative, 2020).

Similarly, in Scotland, there is a strategy called "Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls" (Scottish Government, 2018) which supports the implementation of the Domestic Abuse (Scotland) Bill which came into force in April 2019. This strategy targets violence towards women and girls "carried out predominantly by men directed at women and girls precisely because of their gender. Behaviour that stems from systemic, deep-rooted women's inequality, and which includes domestic abuse...". This gendered approach has defined IPV under a gendered umbrella where violence against women and girls includes physical, sexual, psychological violence that occurs within the home or community and other institutions – including domestic abuse.

However, the Joint Protocol between Police Scotland and the Crown Office and Procurator Fiscal Service (2017) has a gender-neutral definition: "any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and which takes place within the context of a relationship. The relationship will be between partners (married, cohabiting, civil partnership or otherwise) or ex-partners. The abuse can be committed

in the home or elsewhere including online” (p.2). Whilst within the same document it accounts for the fact this definition allows all victims groups to be captured regardless of gender or sexuality, it also goes on to discuss that the majority of domestic abuse is perpetrated by men against women.

By having a gender-neutral definition, it allows for all victims to be given equal opportunity to have their perpetrators prosecuted under the legislation, something required under UK law. However, framing IPV under this gendered framework creates an approach and therefore perceptions that IPV is in the majority perpetrated by men towards women. This is despite figures from the Office for National Statistics (ONS;2019a) detailing that 1.6 million women and 786,000 men were victims of domestic violence in the year ending March 2019; this ratio suggests for every three victims of IPV one will be male and two female which challenges the use of language like “predominantly” or “overwhelmingly “ within the legislation and guidance. A position that was successfully challenged by the Men and Boys Coalition charity in a complaint to the UK Statistics Authority (see Men and Boys Coalition, 2019).

For Northern Ireland, they have a developing Domestic Abuse Bill introduced to the Northern Ireland Assembly in March 2020 (see Northern Ireland Assembly, 2020; Northern Ireland Direct Government Services, ND), and their Stopping Domestic and Sexual Violence and Abuse strategy (see Department for Justice Northern Ireland, 2016) which is a seven-year strategy aiming to reduce domestic and sexual violence. They utilise a gender neutral definition as do the other UK areas, but this is different in its emphasis on IPV being able to impact on anyone: ““threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a



current or former intimate partner or family member' (p.2). Indeed, throughout the strategy document there is a much less gendered focus; there is acknowledgement in some of the key statistics that prevalence is higher for women, but there is much less of a focus on the proportion and a much more inclusive discussion around gender and sexuality (amongst other protected characteristics). This recognises where this fits in line with other gender based violence work but emphasises that it can impact anyone; in their discussion of the definition and strategy generally they do not place emphasis on the female majority as described above despite including statistics that represent the higher prevalence of women's victimisation compared to men's.

### United States

The Violence Against Women Act (VAWA) was passed in the United States in 1994 (Congressional Research Service, 2019). It provided a centralized and fundamental shift in the way that IPV is treated by in the U.S. Whereas once a series of uncoordinated approaches and perspectives, VAWA reoriented the national conversation about IPV and emphasized that it was a crime worthy of federal attention and funding, not just a "domestic issue." Specifically, VAWA created the Office on Violence Against Women within the U.S. Department of Justice, allowed for increased sentencing of some sex offenders, authorized grants to state and other smaller law enforcement entities to prosecute IPV against women, and mandated restitution to victims of some sex offenses. Within this, the overarching goal of VAWA was to prevent violent crime and to emphasize a collaborative effort and response to IPV between the criminal justice system, social service agencies, researchers, schools, public health organizations, and private organizations.

VAWA has been reauthorized multiple times since its initial passing and a cost-benefit analysis of the first wave of VAWA suggested that the federal legislation was effective (Clark et al., 2002). The authors of that analysis concluded that the then benefit of VAWA was \$16.4 billion (in 1998 U.S. dollars) and that the cost to implement VAWA was \$1.6 billion. Considering the cost per capita to each woman, VAWA was estimated to cost \$15.50 for each woman in the U.S. and it was expected to save \$159 for each woman in averted costs of criminal victimization. IPV against women and men has significantly declined since VAWA was passed (Modi et al., 2014).

VAWA was not without its critics, however. The legislation included a narrow scope on which victims of IPV could be served. When VAWA was reauthorized in 2013, the legislation was changed to articulate that all victims of IPV could be served, regardless of gender, gender identity, or sexual orientation (Modi et al., 2014; Congressional Research Service, 2019). Further, national organizations that work to reduce IPV, have promoted and clarified that despite the name of the act, which focuses on women, the legislation is broad in its scope and encompasses all IPV victims (National Task Force to End Sexual and Domestic Violence Against Women, 2006). The reauthorization of VAWA in 2019 broke down over a difference between the U.S. House and U.S. Senate versions of a reauthorization bill. The House's version included a new provision that anyone convicted of domestic abuse will not be able to purchase a firearm; the Senate would not endorse this version of the legislation. As of the writing of this paper (July 2020), the law has not been reauthorized. That said, the law itself does not have a sunset provision and as it stands now, it remains a federal law, albeit with inadequate funding (Rodgers, 2020).

VAWA created new procedures and bureaucracies within the U.S. Department of Justice. In addition to this legislation, which emphasizes the criminal nature of IPV, is the Family Violence and Prevention Services Act (FVPSA), which is administered by the Family and Youth Services Bureau (FYSB), an office of the Administration on Children, Youth and Families at the Administration for Children and Families, all of which are under the U.S. Department of Health and Human Services. FVPSA was first passed in 1984 under the Child Abuse Prevention and Treatment Act. FVPSA provides funding for four main areas (Family & Youth Services Bureau, 2018). First, is public education as a way to increase awareness regarding IPV. Second, the legislation provides funding for shelter and supportive services for those leaving abusive relationships. Third, FVPSA funds a national domestic violence helpline, which in 2017 answered over 323,000 requests for support through a combination of calls, texts, and online chats. Fourth, this federal legislation provides funding for training and technical assistance regarding IPV to community and tribal non-profit organizations, including state domestic violence coalitions and national resource centers. In terms of the overall allocation of FVPSA resources, 70% supports state and territorial grants, 10% support tribal grants, another 10% supports state domestic violence coalitions, and the remaining 10% of funding supports a combination of training and technical assistance, evaluation, monitoring, administration, and discretionary funds.

### **Helplines and Other Similar Services**

An IPV helpline is a community-based telephone service for IPV victims/survivors that offers information, advice and support; supporting victims, their families and others calling on their behalf (ONS, 2019b). In England, the primary helpline is the free 24-hour National Domestic Abuse Helpline which is for female victims of IPV; the Refuge annual report suggests

that 108,918 calls were answered by this helpline in 2018-19 (see Refuge, 2019). Similarly, there is the 24 Hours Domestic and Sexual Violence Helpline in Northern Ireland, the Live Fear Free helplines in Wales (run by Welsh Women's Aid), and Scotland's Domestic Abuse and Forced Marriage Helpline. In the U.S., many cities, counties, and states have their own domestic violence hotlines, but the most commonly referenced and most centralized hotline is National Domestic Violence Hotline. In 2019 this hotline, which will receive calls from any victims, regardless of gender, gender identity, and sexual orientation, responded to 362,897 request for support and assistance (National Domestic Violence Hotline, 2020).

The research on hotlines is limited, but in the UK, one example was a commissioned evaluation of the All-Wales Domestic Abuse and Sexual Violence Helpline by Cordis Bright (2014); they found a 33% increase in calls between 2008 and 2013 with an average of 762 calls per day; an average of 11.2 calls being from victim/survivors and 41.4 from agencies (the remaining were from other categories). Their online evaluation survey received responses from victims, agency representatives and concerned others. Of the 17 victim responses, ten reported feeling supported and safe after calling the helpline, 16 felt confident to deal with their situation. Those calling from agencies (n=209) were positive in their response with 95% saying the quality of the service was either excellent or good, and 94% felt the helpline was a good first point of call for asking about domestic and sexual violence. There are barriers to conducting evaluation research, however. Owens and Nickson (2020), for example, conducted an Evaluability Assessment for the Live Fear Free Helpline in Wales that explored the extent to which the helpline would lend itself for a full future evaluation. Live Fear Free is a helpline run by Welsh Women's Aid and funded by the Welsh Government. The authors identified a number of

challenges for evaluation including a lack of data on how service users engage with the helpline and a lack of resources for evaluating.

There has also been work done in the US, for example McDonnell et al (2018) evaluated the already noted National Domestic Violence Hotline and also “loveisrespect” (a helpline targeting younger people). For the main hotline, they had 500,000 contacts in a two-year period, the most common was by phone (91%), with online chat (8%) and text (1%) being less popular. In contrast, for the loveisrespect hotline, the majority came through their online services (66%), with phone (17%) and text (16%) being less popular, which suggests that younger victims are more comfortable seeking help through an online platform. The researchers reported that the helpline was rated positively by nearly all those calling, and that they found the information and resources provided to be helpful.

Helplines provision for underserved populations is often not centrally or government-funded. For male victims of IPV, there are a number of specific helplines available across the UK. For example, there is the ManKind Initiative<sup>1</sup> based in England which was established in 2001 and was the first charity in Britain to support male victims. Their helpline receives approximately 2,000 calls per year, these are from male victims but also from friends and family members seeking advice on how to support a man they are concerned about. They further offer support to other organisations and agencies including training and presentations, and their “Oakbook” which is a directory of services for male victims designed to be used by qualified professionals. A further key role involves their advocacy for male victims through campaigns, media, research and involvement with Government committees and consultations. Their helpline

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<sup>1</sup> The first author is a trustee of the charity and works closely alongside them.

offers emotional and practical support as well as signposting to local services. It is an anonymous helpline meaning callers do not have to give any identifying information; indeed, their helpline data from 2018-19 revealed that 59% of the men who had called had never disclosed before and 70% of callers would not have called if the helpline was not anonymous (see Brooks, 2020). There are also helplines in Scotland (Abused Men in Scotland), Wales (Dyn Project, AEGIS) and Northern Ireland (Men's Advisory Project). These services offer similar help and support, advocacy and awareness raising, and for the latter organisation they also offer counselling services.

In England and Scotland, the only known government-funded helpline for male victims is Men's Advice Line that is operated by Respect, which is a UK-based organisation that works primarily with male perpetrators of IPV and accredits perpetrator programmes (see Bates et al., 2017 for a full discussion of their perpetrator work and standards). They are also funded by the UK government to run a helpline for male victims of IPV. A qualitative evaluation of this service in 2019 revealed that men had spoken positively about their experience calling the helpline; this included valuing the opportunity to share their experience, and have this experience validated, and feeling a positive outcome associated with receiving support. In a satisfaction score, they averaged 8 out of 10 by the 30 men interviewed (Burrell & Westmarland, 2019). A point of concern in the report was seen in the way the authors responded to men's discussion of false or counter allegations. Despite this being something that has been seen in men's accounts before (e.g., Bates, 2019a; (Hines et al., 2015), the authors said it pointed to challenges in working with male victims "given the possibility that some callers may in fact be perpetrators of abuse, and could be using the call as an attempt to legitimise the idea that they are the 'real' victim" (Burrell & Westmarland, 2019; p10). Indeed, despite some of the men's narratives seen in the data, it is

of concern that the authors further point to “...the wider context of gender inequality and the reality that the vast majority of coercive and controlling domestic abuse is perpetrated by men against women” (p.26).

In general, men in the U.S. have had unfavourable experiences when reaching out to a DV hotline for help (Douglas & Hines, 2011). They have been turned away, denied services, ridiculed, belittled, and accused of being the “real” abuser. In the U.S. the only national helpline that targeted male victims was the Domestic Abuse Helpline for Men (“& Women” was later added to their title), which ran from 2000-2013. The helpline operated almost exclusively with volunteers and was not sustainable over time because of a lack of funding (Post, 2020). Research conducted on callers from the mid-2000s, when the helpline was receiving roughly 225 calls a month, shows that the majority of callers, 77%, were calling about their own victimization, and they called to discuss the physical and emotional abuse that they were experiencing (Hines et al., 2007). There are also organizations, such as Valley Oasis, in California, which serve all victims, regardless of gender, gender-identity, and sexual orientation, and which has operated a 24-hour hotline for victims since the 1980s (Valley Oasis, 2017).

In terms of other typically less well-resourced groups, one of the UK’s only specialist LGBT+ anti-violence charity is called Galop, and it supports people with the LGBT community who are experiencing hate crimes, domestic and sexual violence (see Galop, ND). They support through both a helpline, and through a self-referral, case work service that allows victims to be linked to other LGBT victim/survivor organisations. They further offer information to both victims and professionals. In the U.S., the Northwest Network is one of the most well-known resources that specifically supports members of the LGBT community, seeking guidance and relief from IPV victimization. This organization provides a helpline, counselling, support groups,

and other similar services for survivors. Like Galop in the UK, the Northwest Network in the Washington State in the US, also provides technical assistance and training to professionals concerning how to best meet the needs of the LGBT population (see Northwest Network, ND).

There is a dearth of research evaluating helpline services (and indeed wider victim services) for the LGBTQ+ community. Research that can be found within the area of LGBTQ+ and IPV relates to experiences of member of the community in reference to IPV (e.g., Rogers, 2016), barriers to help-seeking (e.g., Harvey et al., 2014), or victims' experiences of formal and informal support (e.g., Turell & Herrmann, 2008). Where research has worked with professionals, they have explored their experiences of supporting people from within this community. For example, Ford et al. (2013) found in their brief survey of 54 professionals that most had little training to work with this group, but 50% reported they had worked with members of this community at least "sometimes" or "often." Furthermore, 92% of participants reported their organisations lacked staff that were dedicated to working with LGBT victims. Similarly, Tesch and Bekenan (2015) interviewed 10 professionals who worked with trans victims of IPV; across the different disciplines the participants represented, there was agreement about a lack of resources and that many criminal justice agencies to address this gap in provision. The participants in this latter study also agree that more research was needed to explore the issue of IPV within the LGBT community, and indeed there is a clear need for research exploring the effectiveness of service provision.

### **Victim Advocacy Services and Support**

The advocacy model was first developed in the US, followed by the UK, to provide alternative options for women IPV victims, who did not want to leave their home but were still in need of additional support (Howarth & Robinson, 2016). The role of an Independent Domestic



Violence Advisor (IDVA), as they are called in the UK, was first developed in 2005 and whilst based broadly on a model of advocacy, it also represented a specific and distinct approach (ibid). IDVAs are specially trained (through accredited training programs) to work with high-risk victims of IPV ( e.g., those scoring 14+ on Domestic Abuse, Stalking and Honour Based Violence [DASH] risk assessment, Safelives 2015a), at a point of crisis (e.g., after a police call out, when a victim has sought medical help), to address issues around safety for them and their children; they work with victims from the beginning of service engagement to discuss options and engage with safety planning (Safelives, 2014a). The role of the IDVA is important around multi-agency work, and indeed represent the victim at the Multi-Agency Risk Assessment Conferences (MARAC) – which uses a multidisciplinary approach to addressing domestic violence (MARAC; Safelives 2014b). IDVAs are independent of any one particular agency but engage in partnership working with a range of relevant domestic abuse services and agencies (Howarth et al., 2009). This independence is thought to be a significant factor for encouraging victim engagement and being able to challenge other agencies where appropriate (Taylor-Dunn, 2016a).

Although initiated in the US, the field of professional advocacy has generally been less standardized in the US. DV advocates have been part of the backbone of DV agencies (Bennett et al., 2004) and they provide support in many of the same ways that UK-based IDVAs do. Like in the UK, they serve as a primary point of contact and are able to advise on housing options, offer emotional support and referral to mental health services, liaise with child protection services and support a victim through the court process (Safelives, 2014a). Unlike in the UK, these roles have not been centralized and are often not credentialed (Branco, 2020). There has been discussion since the 1980s in the US to credential individuals working in professional

victim advocacy, which included the establishment of the National Advocate Credentialing Program (National Advocate Credentialing Program, 2020). This program is primarily focused on supporting professionals who work with crime-related victims. Individual states, such as Illinois or Oregon, for example, have their own DV credentialing programs, but they are not universal. Further, many DV advocates are IPV survivors themselves (Merchant and Whiting, 2015; Wood, 2017). In the US, DV advocates work in DV agencies, shelters, police departments, health centers, and child protection agencies.

One of the first large-scale multi-site evaluations that explored the impact of IDVA services for female high-risk victims in the UK was conducted across January 2007 to March 2009. Howarth et al. (2009) explored the victim profiles of those who engaged with services, the intervention and resources used, and the effectiveness of these interventions for improving the wellbeing and safety of victims. They reported on a range of in-depth findings including, that the majority of their victims were experiencing instances of “severe abuse” (e.g., rape, strangulation, stalking; 76%) and an even higher majority were experiencing multiple forms of abuse (86%); this presented both an understanding of what “high-risk” looks like in this sector as well as confirming “that the work of the IDVA services participating in this study was well targeted and much needed” (p.8). There was a range of work done with victims including safety planning as the most common (81%) but also support with schools, access to refuge accommodation, housing issues and access to counselling and mental health services. Often it was a range or multiple services that were accessed. The impact of the IDVA service could be seen through important reductions in the number of victims experiencing severe and multiple types of abuse; 57% of the victims reported that the abuse had stopped completely. This was supported by both improved feelings of safety by the victims (76%) and the IDVAs themselves reporting lower

levels of risk (79% of cases). Furthermore, there were improvements seen in coping for 63% of victims and improve social networks for 47%.

Some research has demonstrated the effectiveness and importance of this role. For example, IDVAs have been shown to be effective within rural areas and that the funding of an IDVA is “a spend to save endeavour” (Madoc-Jones & Roscoe, 2011; p. 16) and serve a critical role in a hospital setting (e.g., Dheesa et al., 2020). The same was true for research conducted in a hospital setting in the US. The presence of a DV victim advocate in the emergency department uncovered the existence of DV victimization among patients that was otherwise undetected (Hugl-Wajek et al., 2012). Also, on the positive side, the Whole Lives Scotland report (see Safelives, 2017) revealed that when engaging with an IDVA (known in Scotland as an IDAA; Independent Domestic Abuse Advocate) there were reductions in victims experiencing physical and sexual abuse (73% for both). Despite these positive findings, Rivas et al. (2016) performed a review of any random control trials or quasi versions where the use of advocacy was compared to a control/no intervention group and found that whilst there was some benefit but they were uncertain about how significant these effects were as many of the studies in the review were under powered.

One main area of concern that has emerged from evaluation research concerns the workforce of DV advocacy. Whole Lives Scotland report (see Safelives, 2017) recommended the need for more qualified working IDVAs (they identified 174 completed the training but many were not working in the role), and the need to include them in a wider range of locations. However, the cost of this training is thought to be a barrier for some third sector services with some costing over £2000 each (more for some organisations). These places are sometimes subsidised, for example there were funded places by the Scottish Government at one time, and in

Wales as part of the 2015 Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act there are some fully funded places available on specially commissioned training courses (see Safelives Training, ND). Similarly, in the US, researchers have also noted concerns with the workforce of DV victim advocates which can be associated with high turn-over rates (Behounek, 2011). These include low pay, on-call shifts, conflict with other professional groups, including health professionals and law enforcement, and little workplace support to help with the stress of working with high-risk, traumatized clients. Other research has cited the emotional intensity of the work, the dual role of being an enforcer and simultaneously an advocate, and sometimes working in an unsupportive organizational setting (Merchant and Whiting, 2015). Finally, some advocates have become disgruntled with the movement away from a focus on structural change (Finley, 2010), as opposed to a focus on individual empowerment (Wood, 2015).

In addition, research has shown that there is not consistency in how advocates are used across different high-risk victim groups. For example, Safelives Insights data published in the ONS (2018) report showed only 4% of victims accessing IDVA services were men. The same data revealed that only 5% of the cases discussed at MARAC, were men, and another source evidenced that less than 1% of referrals to MARAC are men and women from same-sex relationships (Donovan, 2010). The ONS (2019b) figures revealed that clients working with an IDVA service up to the year ending March 2019 were overwhelmingly women (96%) and White British or Irish (87%), heterosexual (94%) and did not have a disability (85%). Both the IDVA and MARAC figures reflect an under representation of male and LGBT victims, BAME victims, and disabled victims. For men, the 4% and 5% figures seen above do not reflect the prevalence of male victims; with ONS (2019a) figures suggesting one in three victims are male, there is a

significant under representation of men utilising these services. To be represented at MARAC a victim must have had some level of engagement with service (e.g., reporting to the police) to be assigned an IDVA and be supported through the process. The barriers men face in reporting to these services are known (e.g., see Taylor et al., 2020), and the stereotypes and biases held by service professionals (Machado et al., 2017) may often mean men are not recorded in this way. This is compounded by men's own lack of recognition of their victimisation which reduces their likelihood of reporting (e.g., see Machado et al., 2016). Since DV advocacy is not a centralized support service in the US, these same kinds of statistics do not exist for comparison purposes. Recent research, however, notes that DV advocates report finding it difficult to support trans victims because there is a lack of support from agency leadership (Jordan et al., 2020).

### **Barriers to reporting and help-seeking from services**

There are a number of pathways to help-seeking for victims of IPV, and also a number of associated barriers for all victims in terms of help-seeking and reporting. For women, their route into services may come through health services. Health professionals can be key in identifying where women may have experienced IPV and so need referring to a specialist DV agency (Malpass et al., 2014). However, access to specialist support rarely coming via General Practitioner (GP) referral despite the frequency of consultations around mental health (e.g., depression and anxiety; Evans & Feder, 2014), indicating barriers may exist here that are routed in training needs of professionals in some sectors.

For men, their first point of call in disclosure is often informal, for example through friends and family (e.g., Machado et al., 2016) or through searching online (e.g., Tsui et al., 2010). Morgan et al. (2014) explored perpetration and victimisation of men attending GP practices in the South West of England. Men were most likely to speak to friends or family, but

their next most common choice was the family doctor. Only 1.6% of respondents to their survey had ever been asked by a health care professional if they had experienced any abuse from their partner, and only 1.4% had been asked about their own behaviour. The authors conclude that GPs have a key role in identification of men's experience of abuse through asking in consultations, albeit it they need training to ensure they are doing so in a safe and effective way. Similar outcomes were found in the U.S., as well, where the minority of men who sought help for an injury from IPV victimization were given information for how to obtain help (Douglas & Hines, 2011). Specific training on recognising the needs to male patients can increase confidence for health care professionals and has been associated with small increases in men being more appropriately identified (Williamson et al., 2015).

The referral pathways and systems are not always supportive in aiding professionals to identify male victims; for example, within the UK, the main training and referral programme for GPs is called IRIS; they provide GPs in-house training for domestic violence and abuse, and also a named advisor that patients can be directly referred to (see Bolchover, 2018 for more information). Examination of this programme in more detail reveals it is heavily focused on female victims; indeed their referral to advisor are only available for women with only signposting available for men: "every practice that is IRIS trained is given a male patient referral pathway so that they will be signposted towards services that support male survivors" (Bolchover, 2018, p.5).

Similar findings exist in the criminal justice profession. In the U.S., as the country implemented VAWA and the use of the criminal justice system to curb IPV, they implemented "mandatory arrest" policies. As a result, in instances when both partners were deemed to be violent, both would be arrested. There was pushback from advocates concerning this because

women were being arrested, alongside men (Frye et al., 2007). Protestors argued that the very law which made it possible to use the criminal justice system to fight IPV was being used against women, who were perceived to only use violence as a measure of self-defence (Hamel, 2011). What resulted was the implementation in some states of “primary aggressor” approaches, in which law enforcement were trained to identify who was the primary aggressor. These trainings have been criticized as only providing examples of where men were perpetrators and women were victims.

More historical information tells another story, however. Harvey et al. (2014) reviewed existing literature and collected new qualitative data related to the barriers LGBT people experience in help-seeking. LGBT people are underrepresented in Welsh MARAC, and barriers to help-seeking include not recognising the abuse or not being aware it can occur in same-sex relationships, sexuality being used as a method of control by their abusers, and a fear of a stigmatised reaction. Indeed, within this study the service providers discussed a lack of outreach activity to the LGBT community and victims.

Harvey et al. (2014) participants discussed difficulties in a sector that is gender-binary focused as it presents difficulties for people who identify as trans or non-binary. For example, participants (both service providers and the victim group) raised concerns that women’s only services may not support trans women and that this group may struggle to get refuge spaces. A study with a sample of 92 trans individuals who had experienced PA found that they were more likely to disclose their abuse, as compared to a sample of cisgender (Kurdyla et al., 2019). Given the lack of awareness around this population, it is not surprising that trans individuals were most likely to seek support through a friend or a psychotherapist. Those resources are largely ranked as being helpful.

Donovan (2010) also identified a number of help-seeking barriers for those within the LGBT community including a lack of recognition of IPV in LGBT relationships, lack of understanding from police and services, and a lack of trust that exists between this group and mainstream services. Donovan (2010) highlighted that issues in referral to MARAC are also compacted by the number of previous reported incidents, which as this group are less likely to report, will affect their representation. Their under representation at MARAC is even greater than for heterosexual male victims despite figures suggesting that the percentage of gay male and bisexual men is greater (3.2% and 3.3% respectively) compared to heterosexual men (2.8%). Similarly, lesbian and bisexual women also suffered more IPV (7.6% and 9.1% respectively) compared to heterosexual women (5.6%); ONS, 2019b). A more positive side of this story comes from qualitative research focusing on lesbian women who are in abusive relationships and describes both women who sought help overtly and covertly (Hardesty et al., 2011). In both instances, women reported favourable experiences. If they ran into barriers, they were able to successfully push for equal treatment. Even with these well-documented difficulties, there has recently been significant progress made in the U.S. to reach a widening group of individuals who come forward for victims support services (Morgan et al., 2016). One final issue which has made it difficult for IPV victims in the US to seek help is their immigration status (Reina and Lohman, 2015). If victims come forward for help or assistance, they fear becoming known or identified to Immigration and Customs Enforcement. Previous research has shown that DV agencies struggle with meeting the needs of this population as well (Douglas and Hines, 2011).

### **Accredited services and standards**

With many criminal justice agencies and third sector organisations working with IPV, some organisations have created standards and accreditation processes that are awarded to



domestic abuse services to demonstrate the quality of the work that is done. Within the UK, there are such accreditation processes available for perpetrator programs (e.g., see Bates et al., 2017 for discussion) and also for those working with victims. One such is the Safelives Leading Lights accreditation (see Safelives, ND, Safelives, 2015b); Safelives offer accredited training for service managers, a self-assessment toolkit that helps managers work within their own service towards accreditation, and support and resources to help meet the standards. Each organisation that applies for accreditation is then independently assessed which if successful leads to a three-year accreditation period with ongoing support after.

Service standards have been developed by those working with specific victim groups, for example, Respect have developed both a toolkit for working with Male Victims (see Respect, 2019a) and standard for working with male victims (see Respect 2019b). There are also service standards for male victims of domestic abuse being developed by the UK organisations ManKind Initiative and Hestia, in line with the Male Survivors standards for male victims of sexual violence (see Male Survivors Partnership, ND).

The Respect Male Victims standard (2019b) discusses requirements for working with this group across four areas of provision “1. Governance and management; 2. Intervention Delivery; 3. Diversity and Access; 4. Multiagency work” (p.6). Organisations seeking accreditation have to demonstrate they meet these standards across these areas. The standards are clear in ensuring that organisations respond to men’s gender specific needs, the barriers they may experience in reporting, and their needs-based approach. However, there has been criticism of their approach to assessment when male victims first call.

The toolkit refers to the work of Evan Stark and categories from Johnson’s typology (e.g., 1995) and accurately captures the range of different behaviours a man can experience

including (but not limited to) coercive control, physical violence by use of weapons, sexual abuse, and using the children as a tool. They also describe additional experiences and barriers experiences by men within the LGBTQ+ population. In the toolkit, they refer to assessment processes which are related to finding out whether the victim calling has also engaged in any perpetration; “we find that what the client tells us usually helps us to identify which category of client they are in – they might present as a victim but listening to what they say about their experiences helps us to work out that they are in fact a perpetrator” (p.17). This process involves finding out about “who is doing what to whom, with what consequences and in what context” (p.40) and indeed include a checklist to go through with a caller and reference to evidence of this (see p.41-42 of the toolkit). Whilst they state that “we don’t assess clients because we don’t believe them, we assess them because we want to meet their needs appropriately,” (p.17), this function may indeed serve to make any male callers feel they are not believed which is one of the most frequently referred to barriers to help-seeking (e.g., Bates, 2019c). This is indeed reflected within the standards where they state: “Some perpetrators present as victims and need a response which addresses this” (p.9), not something seen within the standards available for organisations supporting women (e.g., see Women’s Aid National Standards, 2018). They do not advocate different assessment processes for male and female victims, but they as an organisation do not work with female victims, and indeed their standards are only in reference to male victims.

This toolkit also recommending gathering personal information from the caller. This is something that is likely to put off some men who call due to the barriers they already experience in help seeking, indeed as mentioned earlier, ManKind Initiative (see Brooks, 2020) helpline data revealed that 70% of callers would not have called if their helpline was not anonymous. This anonymity is an important factor for some men to disclose; Bates (2019b) found in the

anonymous, online qualitative survey ( $N=161$ ) that 25.6% of men had never disclosed their experience to anyone else.

An assessment process is seen in other male victim helplines; for example, the Dyn Project in Wales (see Dyn Wales, 2014). The use of an assessment tool was challenged with the Equality and Human Rights Commission (EHRC) as a discriminatory approach because this was not done with female victims. This challenge was successful in 2017 and the EHRC changed its approach (see Western Mail, 2017). However, current exploration of the Dyn Project training page reveal this may not still be the case as part of their one-day training course includes “How to identify men, on a scale from victim to perpetrator through the use of the Dyn assessment tool.” This is thought to be related to the fact they only support one gender in their service and so it is not treating one group differently within that organisation.

As previously noted, the UK has a more standardized approach to credentialing and the standardization of services. There are some robust efforts to standardize approaches within the US , such as through common trainings and approaches. These can be organized through the National Coalition Against Domestic Violence and their associated chapters, as well as the National Resource Center on Domestic Violence, or the National Network to End Domestic Violence. Federal funding, philanthropic groups, and private gifts support these organizations and make it possible for them to carry out their missions and work. All of these organizations exist to provide a unified voice for federal legislation and to also provide support to state-level and other local initiatives. In the latter capacity, they provide training and technical assistance for front line workers, managers, supervisors, and executive directors concerning best practices, new research and approaches, resources, toolkits, and troubleshooting. For example, since 1994, the National Resource Center on Domestic Violence has responded to 60,000 inquiries (National

Resource Center on Domestic Violence, n.d.) about policy, best practices, and from professionals, family and friends of victims, employers, and students (National Resource Center on Domestic Violence, 2018). All of these organizations host conferences and provide training and webinars as the leading DV organizations in the nation. Further, they informally set the standards for the field in terms of practice, membership, and approach.

### **Therapeutic Interventions**

Since 2013, there have been a range of empirical studies and further reviews, exploring the effectiveness of some of the therapeutic interventions that are offered. For example, Arroyo et al. (2017) explored the effectiveness of short term IPV victim interventions in a systematic review and meta-analysis; they found that many interventions yielded large effect sizes with those based in a CBT approach associated with the largest. Similarly, in their systematic review and meta-analysis Tirado-Munoz et al. (2014) concluded that advocacy and engagement with CBT interventions had the effect of reducing women's experiences of physical and psychological (although not sexual) IPV.

Beyond this, research has explored the impact of new interventions, including trauma focused therapies such as trauma-sensitive yoga alongside group work (Clark et al., 2014), as well as technology enhanced mechanisms to reach more rural populations (e.g., Gray et al., 2015). There has also been further suggestion of alternative therapies such as couples counselling (e.g., Antunes-Alves & De Stafano, 2014) which data suggest could be effective in some select circumstances (e.g., Karakurt et al., 2016).

Within the UK, there are also a number of “pattern changing” courses which are for victims (primarily women) who have been in an abusive relationship and are still living with the

adverse effects. For example, Howarth et al. (2009) found their IDVA sample reported around 10% of the victims completed a pattern changing course. The Freedom Programme was created by Pat Craven; based on her work with male perpetrators, she developed a programme that was for the women who had been abused to understand and make sense of their own experiences, it is grounded in a feminist understanding of domestic violence with Duluth model influences. There is some evidence of evaluation of this programme; Williamson and Abrahams (2010) evaluated the programme in Bristol with surveys completed initially, as well as either at exit or completion. Despite women describing that at times they felt overwhelmed, those who completed and were willing to discuss their experiences after were positive about it, this was with a particularly low sample size though. Taylor-Dunn (2016b) evaluated the 2-day training course for professionals seeking to understanding how the training impacted those working in the area; participants reported feeling they were in a better position to identify patterns of abusive behaviour, understand victim's levels of fear, and an increased understanding of how a perpetrator may use children to control (both pre- and post-separation).

The Freedom Programme was designed as a 12-week programme run for women. It is also provided as a two-day intensive course for men “whether abusive and wishing to change their attitudes and behaviour or whether victims of domestic abuse themselves” (Freedom Programme 2015, cited in Wallace et al., 2018, p254). This presents issues in terms of perpetrators and victims being grouped together in this setting, and also the fact it is significantly shorter than the course offered for women. In contrast, in Wales, there is a programme designed specifically for male victims. The Compass Programme (from Calan DVS) “is a specialist resource designed to help male survivors recover from their experience following self-acknowledgement of having been the victim in an abusive relationship” (see The Compass

Programme ND). It works with men to increase wellbeing, confidence and self-efficacy, and be resilient in spotting signs of IPV as well allowing the opportunity to be part of a wider support network of men with similar experiences. From the available information it is much more tailored to men, rather than simply being adapted as a version for women; the same organisation also run groups for women (including the Freedom Programme), children and families. Whilst no published evaluation is currently available, the programme has been through an evaluation process and has been amended and updated as a result (Wallace, 2020).

Issues discussed in Eckhardt's et al.'s (2013) original review highlighted that there were methodological issues with the research up to that time. These issues are still apparent within some of the more recent work with there still a lack of methodological rigorous outcome-based studies and a lack of those that reflect the diversity of the IPV victim survivor population (Arroyo et al., 2017), as well as reviews being affected by heterogeneity in interventions (Tirado-Munoz et al., 2014).

## **Shelters and Refuge**

Refuge or shelter services for victims of IPV provide emergency and temporary accommodation for those escaping abuse, with therapeutic and practical support (ONS, 2019b). The first shelter in the UK was opened by Erin Pizzey in 1971 (see e.g., Pizzey, 2011). Refuges and requests for accommodation can be progressed through self-referral, police, citizen's advice, the Samaritans or an IDVA (Women's Aid, 2019a). Across the UK figures reveal the uptake of refuge by women and their children; for example, Women's Aid's (2019b) national report suggests 2,616 survivors accessed refuge services in England in 2018/19. Similarly, in Welsh Women's Aid 2018-19 report suggests 2,482 survivors were supported by their members' refuge services, and for Women's Aid Federation Northern Ireland (2019) they reported that during the

year 2018-19 654 women and 421 children stayed in refuge. Importantly, both the Welsh and Northern Ireland branches reported the numbers that were unable to access refuge support through a lack of resources or capacity – this was 431 and 381 respectively. In a slightly different metric, Scottish Women’s Aid census day (27<sup>th</sup> September, 2018; see Scottish Women’s Aid, 2019) 345 women and 348 children were living in a refuge. Refuge annual report (see Refuge, 2019) suggests in 2018/19 1288 women accessed refuge provision – they run 41 refuges across 22 local authorities in the UK.

Using the National Intimate Partner and Sexual Violence Survey from 2015, the US Centers for Disease and Prevention provides estimates on the number of victims who “needed” housing services for IPV victimization at any point in their lives, but doesn’t actually indicate if housing services were used or not (D’Inverno et al., 2019). These statistics show that almost 3.3 million women will need housing support services because of IPV victimization. Men were assessed for this same question, but not enough men responded in order to provide reliable statistics. The National Network to End Domestic Violence conducted a one-day census in 2007 across the US and determined that in total, 11,836 IPV adult victims were using housing services on that day: 8,249 were using emergency services and 3,587 were using transitional housing services (National Network to End Domestic Violence, 2007). The recipients of services were not broken down by gender or sexual orientation.

Some UK based work has focused on those who face barriers to seeking refuge support. The “No Woman Turned Away Project” (NWTAP) is run by Women’s Aid and has been funded by the UK Ministry of Housing, Communities and Local Government since January 2016. It is work that give support to women who face barriers in accessing refuge or shelter space. Since 2017, each year a “Nowhere to Turn” annual report has been published that reveals insights into

the experiences of the women these specialist practitioners have worked with. The latest report, published in the first half of 2020 reports on data collected between January 2019 – January 2020 and monitors and analyses the experiences of the women they work with to better understand where the biggest barriers lie; during this time there were over 423 referrals (including some repeat referrals) of women who were facing barriers to accessing a service, and 243 women had engaged with this service and completed this engagement in the time frame above (Austin, 2020). The report shows that of the 243 women who engaged, 43% were from Black and Minority Ethnic backgrounds (105 out of 243) which the author said this was: “reflecting the systemic racism that Black and minoritised women continue to face when trying to access places of safety.” (Austin, 2020, p.8). The report further discussed the most common challenges to accessing support for these women, this included feeling tied to the local area, support needs for mental health and having no recourse to public funds. For this report, 24.7% were eventually placed in a refuge; for those remaining they had support (for example) from friends and family, stayed in a hotel, but for others 8.2% were staying in the home they shared with the perpetrator of their abuse, and 1.6% returned to their perpetrator. Many of the women still described the support they received from the service as “invaluable” (p.16) which included emotional and practical support.

Research has explored the impact of refuges and shelters on those who reside in them (e.g., Sullivan et al., 2008) and evaluating the outcomes of any interventions with victims of domestic violence is “an essential element of accountability to survivors of domestic violence” (Laing, 2003; p.11). Indeed, shelters and refuges are perceived as having significant benefits that justify the cost and resourcing of them (Chanley et al., 2001). Other research has indicated the wider fiscal rewards; a Social Return on Investment analysis in 2016 of UK services run by the



organisations Refuge indicated a “For every £1 invested in Refuge’s specialist services, clients, their families and society at large receives an average social reward equivalent to £4.94. For some services the ratio is even higher – outreach services generate £6.92, Independent Domestic Violence Advocacy services generate £7.14” (see NEF, 2016; p.2). Research exploring the impact of IPV on women has utilised shelter samples to assess factors that are impactful for women such as mental health needs (e.g., Karakurt et al., 2014) and levels of depression (e.g., Campbell et al., 1995). There has also been research exploring the effectiveness of different services and interventions within these settings. For example, trauma-informed services have been associated with improvements in self-efficacy (e.g., Sullivan et al., 2017); counselling programs have also been found to have small yet significant impacts for women including increased self-efficacy and increased coping skills (Bennett et al., 2004). Social support interventions have also been found to be effective; Constantino et al. (2005) found their intervention group showed significantly improved ratings of psychological distress compared to a control group. They concluded that social support interventions within these settings could be an impactful way of improving the health outcomes of women who reside. There has been less research more recently exploring experiences of working and living in a shelter/refuge environment from either a resident or service providers. One such study that has, explored the impact of living within the rules of a refuge environment. Glenn and Goodman (2015) reflect that with increasing resident numbers and increased diversity of residents, there was a need for increased structure and rules. The resident participants in this sample reported some difficulties with how these rule were enforced, particularly the rules that restricted contact with wider social networks (as per safety concerns), they reported a lack of emotional support from staff, and others felt the “surveillance” behaviours they experienced from staff enforcing these rules

reminded them of the behaviour of their abuser. The authors of this paper are clear to highlight that these results are likely a function of not necessarily understanding the reasons that staff had to enforce these, especially in response to the changes described above; they refer specifically to the possibility of secondary trauma and staff burnout. Indeed, other research has highlighted the challenges faced in retaining staff working as advocates within this environment (Merchant & Whiting, 2015).

The statistics around mainstream provision, and indeed the research described above, is exclusively related to that offered to women and their children. There are significantly fewer resources and capacity for male victims of IPV; the disparity in refuge provision can be seen in statistics collated by the ManKind Initiative. They revealed that in the UK there are currently 37 organisations that offer shelter and refuge space for men, which includes 204 spaces with 40 of these dedicated specifically for men (Brooks, 2020); this is in contrast to 269 organisations and 3649 spaces for women (Parliamentary Select Committee Report, 2017). Furthermore, their helpline data revealed that in 2010 on at least 120 occasions a man had to refuse a refuge space or safe house accommodation because it was geographically too far away (i.e. away from their jobs, children) and research with four safe house providers showed that men were having to travel on average 160 miles to find a place (ManKind Initiative, ND). Many parts of the UK do not have refuges or safe houses for men such as London or East Anglia; although at the time of writing (July 2020), after a number of years of campaigning additional funding has been announced by the Mayor's Office for Policing and Crime (MOPAC) to provide accommodation in London for men escaping abuse.

The US has faced similar barriers in terms of providing support for victims who are not straight women. Research focusing on DV agencies has shown that shelters have had limited

capacity to provide housing services to trans individuals and men with any sexual orientation (Hines & Douglas, 2011). Agency directors reported that the underserved population that they were most able to meet was lesbians. And, in general, with regard to all underserved populations, they were most able to provide hotel vouchers and less able to provide shelter services, safe homes, and transitional housing. Since this study was conducted, however, there have been significant gains in agencies meeting the shelter needs of underserved groups. This has especially been true with regard to men. For example, the US Department of Health & Human Services recently held a roundtable in Washington, DC where they brought together agency directors who actively provide housing and other services to men who were victims (U.S. Department of Health & Human Services, 2018). Both current authors also has countless examples of where agencies have contacted her because they are expanding services to include men and they are seeking an evidence-based approach.

## **Technology**

The presence of barriers to service engagement has presented practitioners with the need to explore a range of options in which they could try and reach IPV victims. One such way could be through the use of technology and online support; this is something that has already been explored in part with specific harder to reach groups for example, exploring technology enhanced mechanisms to reach more rural populations (e.g., Gray et al., 2015).

An example of technology enhanced support for victims can be seen in the UK where the organisation Hestia, along with other partners, developed the mobile app “Bright Sky” (see Hesita, ND). As an app, it is designed to look like a weather app in appearance, but provides support and information for victims of IPV, people who are worried about someone in an abusive relationship, and also for employers and practitioners looking for more information. It has

features that include a UK directory of IPV support services, questionnaires to assess safety, a section on myths around IPV, and a secure “My Journal” tool that allows users to record incidents of abuse without any content being saved onto their mobile device.

There has been a focus in the research of exploring the ways in which technology can be used as a tool of abuse for example, research has shown that IPV perpetrators have threatened to share sexual content online (e.g., Woodlock, 2017), experiences of cyber IPV in young people (Zweig et al., 2013), that IPV professionals and survivors often do not feel they understand technology enough to cope with online or cyber enabled IPV (Freed et al., 2017), how damaging this abuse can be to victims (e.g., Freed et al., 2018), and prevalence of online emotional violence (e.g., Barter et al., 2017). It is important to note, for example, that video conferencing is increasingly being used to work with hard-to-reach populations in order to deliver healthcare education, information, coaching, and check-ins about physical health conditions (Hall et al., 2012; Friesen et al., 2015) and psychotherapeutic services (Kozlowski and Holmes, 2014; Marziali et al., 2006). Some have argued that using online communication tools in providing healthcare and psychotherapy among high-risk populations, but not necessarily IPV victims, may increase participant comfort and lead to higher rates of disclosure (Saber et al., 2013; Lingley-Pottie and McGrath, 2008; Simpson et al., 2015).

That said, the extant literature is limited in terms of how to support and engage IPV victims. For example: Rempel et al. (2018) performed a scoping review to explore online interventions available for women who had experienced IPV; they reviewed literature between 2000 and 2016 and identified 11 interventions. They found that online interventions seemed to focus on helping women escape the abuse and less on the support needed to cope with the next stage. Research has also suggested there is variation in readiness of professionals to engage with

technology-based applications for supporting victims (e.g., Murray et al., 2015). Yet with other research suggesting online services are the most popular methods to reach younger people (e.g., McDonnell et al., 2018), there is a need for services to consider engaging more with technology to ensure all options for access to support are explored.

### **Recommendations for research, legislation and service provision.**

Eckhardt et al. (2013) highlighted several issues with the research they reviewed that included a lack of longer term follow up, a lack of exploration of victim's own aggression, and a lack of exploration of male victim (and female perpetrator) intervention groups. Within the current paper, a review of the literature has left many of these issues still present, and so our recommendations overlap to an extent with the original review. From the current review of the victim services and existing research in the UK and the US, we have a number of recommendations in reference to legislation and service provision, and for research and evaluation.

Firstly, there is a need for policies and legislation that are inclusive in both "name and spirit." The review of the policy that exist within the UK and US revealed definitions that were often gender-neutral and allowed inclusivity of the range of victim groups but were often positioned under gendered strategic frameworks. For example, both within England and the US, the gender-neutral definition sits under the Violence Against Women and Girls Strategy (UK) and the Violence Against Women Act (US) and much of the language used within these documents refers to the notion that men are primarily perpetrators and women primarily victims. The review has also highlighted a number of barriers that some underserved victim groups face in accessing help and support, with evidence seen both in the academic literature, and in these groups' lesser presentation to services (e.g., IDVAs, MARAC). Positioning IPV under this

framework will serve to exacerbate issues where these victims do not “see” themselves within the legislation or service provision. Furthermore, how this is positioned will filter into the public narrative around IPV which then may impact on service providers and practitioners, often allowing for such abuse of these systems (e.g., through legal and administrative aggression, see Tilbrook et al., 2010; Berger et al., 2015; Hines et al., 2015).

Our second set of recommendations concern services. DV advocacy is a profession in need of addition. Even though this field has been standardized in the UK and there are some state-specific standards in the US, research shows that these professionals could use a higher level of training and availability, in general. Staff turnover rate is high, working conditions are challenging, and sometimes agencies are not able to provide advisors and advocates with the level of support that they need or desire. In a field that could always use additional funding, it is unrealistic for us to recommend that more resources be directed to this area, but that is in fact exactly what we recommend.

Further within the service domain is a relative lack of resources and provision for those who sit outside the male perpetrator/female victim narrative. We see within both countries, that provision for male victims, those victims within the LGBTQ+ community, and children is significantly less available compared to that for heterosexual female victims. This is also likely to be exacerbated by intersectionality with other protected characteristics (e.g. for men who are BAME, or those who are disabled). It is also important that we see services that are gender-specific or responsive, and true tailored provision. Service users all need support to cope with the emotional impact of IPV, but there are also group-specific differences and needs that we must recognise in practice (Hester et al., 2012) and indeed, IPV victims and survivors who approach services across a range of settings present with diverse needs (Arroyo et al., 2017). Applying a

model of service that works for one victim group may not do so for others, rather provision should be tailored to the needs of the victim groups, and where possible the individual.

Linked to this is a need to ensure practitioners are trained and understand these individual needs. Gender-responsive services would require gender-responsive training for staff; indeed, some of the research indicates that staff with dedicated responsibility for specific victim groups are often lacking (e.g., Ford et al., 2013) and there are often a lack of dedicated resources, too (e.g., Tesch & Bekenan, 2015). Furthermore, this lack of specific training is often specific to these underserved groups; for example, some practitioners supporting men within the UK have reported they do not get the same training, support or caseloads as those who were supporting female victims (Selwood, 2020). In this paper we have highlighted a number of issues that are specific to some victim groups.

Finally, with regard to research, there is a need for more research, in general, and more rigorous research. First, there is a need for more research to understand what services are desired, available, used, and the efficacy of these services. This is especially true in the US, where there is limited data collection on the national level in all of these areas. The research that exists on DV is largely consumer satisfaction and rarely ever randomized, controlled trials or even comparison groups of any kind. We cannot know the efficacy of services without more rigorous research methods, which makes it challenging to then argue for more funding.

In addition, the majority of research attention has been paid to services that work with women who are victims of abuse from male partners. This fits with the historical narrative that IPV only happens to women and as a result, research has historically focused on services working with men's perpetration and women's victimization (e.g., see Bates et al., 2017 for discussion), often working with men who are in prison or treatment programs (e.g., Loinaz,

2014), and women who have resided in shelters or refuge (e.g., Campbell et al., 1995). There is a growing body of literature that captures the experiences of all IPV victims, regardless of gender, gender identity, or sexual orientation (e.g., Hines et al., 2007; Douglas & Hines, 2011; Reuter et al., 2017), but there are still substantial gaps in this literature as well which demands attention from researchers today.



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