Abstract

Despite longstanding investigation into the experiences and needs of female victims of domestic violence and abuse (DVA), and a burgeoning literature on abused men, information on service engagement by both of these groups is limited, particularly in direct comparison. This is in part due to a lack of large-scale quantitative data on victim needs upon presentation to services. The current study presents the first of a two-part examination of data collected from specialist DVA services in the UK supporting predominantly high-risk clients between 2007 and 2017. Case data from a total of 34,815 clients (858 men and 33,957 women) was assessed across five key areas: demographic characteristics, routes of referral into service, context of abuse, reported abuse type, and outcomes and risk factors of abuse. Clients tended to be white, with men being older on average. Men and women had similar referral routes, but men were more likely to have a disability of some kind and women were more likely to have children living/visiting the home. Men were more likely to report physical abuse than women, whilst women were more likely to report sexual abuse and harassment/stalking. There were no significant differences in the frequency of reporting jealous/controlling behaviours. Results also showed that women were more likely to have attempted to leave, and to call the police, with men more likely to suffer from alcohol/drug problems and reporting poorer physical health. However, it should be noted that almost all such differences had small effect sizes, suggesting greater similarity between male and female clients than difference. Results are discussed in the context of the importance of recognising both the shared and unique risk factors of client groups upon presentation to services.

Keywords: domestic violence; help-seeking; service engagement; service provision; gender inclusivity

Introduction

Domestic violence and abuse (DVA) is defined in England and Wales as "any incident of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of their gender or sexuality"[1] (Crown Prosecution Service, 2019). When in reference to violence within romantic relationships, DVA is sometimes used interchangeably with the term intimate partner violence (IPV – which is the focus of this manuscript). DVA is widely described as a global health crisis, as reflected in statements by international bodies such as the World Health Organisation (WHO, 2017), the United Nations (UN Women, 2019), and the European Parliament (European Parliamentary Research Service, 2019). Such acknowledgement follows more than seven decades of advocacy for the recognition of interpersonal violence, and its severe impact on both physical and mental health (Dutton, 2011). As a consequence, though substantial international variation exists, many countries, such as the UK, have extensive domestic violence policy frameworks in place, (such as the Violence Against Women and Girls Strategy; HM Government, 2016) which serve to politically underpin and fund service provision for victims.

However, despite such provisions, significant challenges to effective service delivery persist. For example, the provision of services does not automatically translate to ease of access or effective engagement. Moreover, prevalent negative attitudes and stereotypes around DVA have been identified as preventing victims from engaging with support (Overstreet & Quinn, 2013). This is particularly the case than for under-represented or so-called 'hidden' groups, such as male or LGBTQ+ victims, who may experience additional barriers to help-seeking resulting from additional stigma, and shame (Bates et al., 2019; Hine, 2019; Laskey & Bolam, 2019), and where lack of political recognition often translates to

[1] The full definition provided by the Crown Prosecution Service also references intimate violence between family members. However, for this study refers solely to violence between intimate partners.

under-resourcing and ineffective service provision (Laskey & Bolam, 2019; Wallace et al., 2019b).

The present study outlines the first of a two-part analysis carried out on secondary data collected from various specialist domestic violence services across the UK between 2007 and 2017. In this first part, we examined and explored the demographic characteristics, reported context and type of abuse, and outcomes of male and female victims of opposite-sex[2] partner violence upon their presentation to services. The second part, detailed in a complementary manuscript (Hine, Bates, Graham-Kevan, et al., 2020), will present analyses in these same areas upon exit from specialist services, as well as criminal justice outcomes. Both individually and in combination, both manuscripts will help to provide much needed, in-depth analysis currently lacking in this field.

Female Victims and Engagement with Services

There is a long-established literature outlining the aetiology, experiences and health-related outcomes of DVA against women. Feminist activists and scholars often describe the origins of DVA as patriarchal, arguing that such violence is an expression of men's desire to control and dominate women with the goal to enforce male privilege (DeKeseredy, 2011; Felson, 2002). Termed the 'gendered approach' in this article, this model is reflected in many public policy and intervention frameworks designed to address DVA, both nationally and internationally (Bates et al., 2017). Such approaches have led to a highly enriched and valuable understanding of the severity and variety of violence experienced by women (Garcia-Moreno et al., 2006), as well as the potential long-lasting impact on physical and mental health (Ellsberg et al., 2008; Ferrari et al., 2016; Loxton et al., 2006). In addition, it has also led to the rapid expansion of specialist DVA services for women (e.g., UK Women's Aid, Refuge). Almost all are delivered in line with the theoretical approach outlined above, in

[2] It is important to note that both manuscripts focus on data relating to male and female victims of domestic abuse from an opposite-sex partner (see Method for full explanation). Data relating to LGBTQ+ victims will be explored in a separate, upcoming manuscript.

that they seek to provide support for women and children experiencing abusive settings, both within third-sector settings and the wider community (Women's Aid, 2019). However, although informational campaigns tend to focus on the more severe cases of DVA against women, there is in fact wide variation in exposure and impact. In addition, not all victims accessing these services are female or the victim of male directed violence and abuse, and many services explicitly fail to recognise such victim groups (Bates & Douglas, 2020).

Within the UK DVA support organisations provide statistics on their provision which include demographic information on who has accessed the service, and the nature of abuse suffered (e.g., the Women's Aid Domestic Abuse Annual Audit, 2020). Such statistics can provide some indication of both the successes and remaining challenges in facilitating women's engagement with support services, such as a lack of accessibility for ethnic minority women (Burman et al., 2004; Kulwicki et al., 2010; Yoshioka & Choi, 2005). However, such information is usually limited to only one individual provider, within a particular calendar year. There is, therefore, still an urgent need for further information on women's engagement with specialist DVA services within the UK, taken across a broader timespan and variety of service providers, to help identify potential improvements to service provision.

Male Victims

Far less is known regarding the experiences and health outcomes of male DVA victims. This is in part due to the historical focus by the approaches outlined above on men as perpetrators only, and the associated "gendered paradigm" within academic literature (Dutton & Nicholls, 2005; Dutton & White, 2013; Hine, 2019). Nonetheless, increasing recognition of male victims has been supported by a burgeoning literature base highlighting not only the serious and wide-ranging abuse suffered by men (Bates, 2020; Drijber et al., 2013; Hine, Bates, & Wallace, 2020; Hine et al., 2021; Hines et al., 2007; Hines & Douglas, 2009, 2010a,

2010b), but the potentially severe physical and mental health outcomes of abuse (Hine, Bates, & Wallace, 2020; Hines & Douglas, 2011, 2015, 2016; Hines & Straus, 2007; Tsui, 2014). Additionally, gender-specific issues have started to be explored, such as the manipulation of father-child relationships (Hine, in press; Hines et al., 2007), the use of legal and administrative aggression (Hines et al., 2015; Tilbrook et al., 2010), and false allegations (Bates, 2019a), as well as the pervasive impact of stereotypes relating to masculinity (Bates, 2019b; Hine, 2019; Hine, Bates, & Wallace, 2020).

Men's help-seeking behaviour and engagement with services is also less understood, with the few studies which have explored this topic suggesting that the gendered paradigm adversely affects men's recognition that their partner's abusive behaviour is DVA and even when men do recognise this, the perception that services are for women hinders help-seeking (Hine, Bates, & Wallace, 2020; Huntley et al., 2019). Moreover, the public faces of many DVA organisations are not only explicitly gendered towards female victims (Huntley et al., 2019), but also implicitly gendered, with men reporting not being believed, being ridiculed, or suggesting they were somehow responsible for the abuse (Bates, 2019b; Safelives, 2019b). Examples also exist of some agencies believing that male clients are actually perpetrators pretending to be victims (Archer et al., 2012). As such the sector appears a "female domain" which largely does not recognise men (Machado et al., 2017; Wallace et al., 2019a) and stigmatises those it does (Hester et al., 2012). This may be why men typically do not seek support from domestic abuse agencies, and that those that do may need to display additional vulnerabilities, or appear at extremely 'high-risk' to be treated as 'victims', and receive appropriate support.

Overall, research finds that the quality of service provision for men is, at best, mixed (Bates, 2019b; Huntley et al., 2019) due to a lack of political recognition and the chronic under-funding of services for abused men that follows this (Hine, Bates, & Wallace, 2020;

Hine et al., 2021; Wallace et al., 2019b). Importantly, limited service availability acts as a significant barrier to developing further research around men's service user experiences, where a lack of information on the prevalence and experiences of male victims, and a lack of service provision and support, mutually inform one another. This can best be described as a negative, self-fulfilling cycle, resulting in a lack of understanding within both academic and practitioner literature on how to best engage men, and what effective provision looks like for them as a population. More information on men's engagement with specialist services is therefore much needed, both to strengthen our existing knowledge of their experiences, and to inform our understanding around the construction of effective and inclusive support.

Exploring Gender-Specific Experiences

As part of the investigation into the experiences and needs of female and male victims respectively, similarities and differences between the two populations have inevitably emerged. For example, many barriers to help-seeking are seemingly shared between female and male victims (e.g., shame and stigma relating to victimisation; Huntley et al., 2019; Nicholson, 2010), as are several needs (e.g., the need to feel safe and supported; Bates, Hancock, & Peterkin, 2001; Hine, et al., 2020, 2021). Several of the challenges relating to provision of effective services are also shared, not least with regards to lack of resourcing and funding across the sector (Hine, Bates, & Wallace, 2020; Ishkanian, 2014; Wallace et al., 2019b). Numerous gender-specific issues have also been highlighted, particularly for male victims (e.g., additional stigma due to masculine stereotypes; Huntley et al., 2019) and associated service provision (e.g., lack of political recognition; Wallace et al., 2019b).

However, such comparisons are, at present, drawn theoretically, and across separate, heterogeneous samples and methodologies. Put simply, there have been very few opportunities to directly compare the characteristics, reported abuse types, and outcomes of help-seeking male and female victims, largely due to the often-segregated nature of data

gathered on each group, collected in isolation by organisations which support one, or the other, population. The assessment of data which has been collected with methodological consistency, and in a significant quantity of both men and women, would undoubtedly provide a valuable opportunity to assess such characteristics of abuse victimisation within the context of victim gender, which would, in turn, allow for an accurate assessment of service needs.

The Present Study

It is clear that there are still significant gaps in understanding abused men and women's engagement with services, and associated needs. As the first of a two-part exploration, the present study analysed case data collected from specialist domestic violence 'third sector organisations'[3] across the UK, on victims' presentation[4] to services. Case information included demographic characteristics, reported abuse context and type, and outcome/risk factors for both female and male service users, abused by an opposite-sex partner, accessing services between 2007 and 2017. The study had two research questions, outlined below:

> RQ1: What were the demographic characteristics, reported abuse context and type, and context, and outcomes and risk factors of service users upon presentation to services?
>
> RQ2: On which variables, if any, were there significant differences between male and female victims?

[3] 'Third sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

[4] Presentation is defined as when the first meaningful contact takes place with the client (e.g. the first formal session). The 'intake' form does not have to be fully completed in this first session, but should be completed within the first three sessions.

Method

Data Set

The data for the present study was provided by a nationwide charity[5] in the UK; an organisation which designs and helps to deliver multiagency responses to DVA, both through their close work with other agencies, development and implementation of interventions, and research. The charity gathers data on DVA from other non-governmental organisations charities and organisations across the UK through a dedicated portal, collected by caseworkers from victims upon engagement with, and exit from, frontline DVA services.

Most of these services are based in England and Wales, though the geographical spread of services is dictated by (a) the density of specialist services across different regions (with higher concentrations occurring in the Northwest and Northeast of England), (b) the willingness of services to provide data, and (c) the active desire of services to use this method of data collection. A minority of Scottish services also provided data. Moreover, some services provided data across the entire time frame examined (2007-2017), whereas others were intermittent. The highest number of services providing data at any one time was 40, in 2015-16. Greater detail on the specific types of services is hard to provide due to, the anonymised nature of the data, the variety of services that contribute to data collection processes, and the acknowledgement that services change or adapt the services provided over time. However, all those providing data were frontline DVA services, including refuge and outreach services, and, regardless of the service, data was almost always collected by independent domestic violence advisors (IDVAs[6]), or other outreach professionals[7], including those working at refuge services (Safelives, 2021). It is important to note that many of the

[5] In the UK, The Charities Act says that a 'charity' is an institution which is a) established for charitable purposes only, and b) subject to the control of the High Court's charity law jurisdiction

[6] An Independent Domestic Violence Advisor (IDVA) is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. This role is designed and commissioned to work predominantly with high-risk clients.

[7] An outreach professional will provide one-to-one support for victims and survivors of domestic abuse who are not assessed as at imminent risk of serious harm, but where there is the potential for serious harm if the situation changes

services providing data work exclusively with female victims, that very few services worked exclusively with men, and that those that worked with both male and female victims were typically services originally commissioned for women and have now expanded provision to men. For an overview of the current landscape of services available to male victims in the UK see Hine, Wallace and Bates (2021) or Bates and Douglas (2020).

It was practice for the information gathering form to be completed by every client seen by a caseworker, though there are some rare exceptions (e.g., if the client refuses consent to research monitoring, or if they only engage with a service briefly). In this sense, the sample presented here will be representative of the vast majority of individuals who engaged with the services who contributed to the data collection process across the time span covered in this study (2007-2017). Just under half of these clients were designated as 'high-risk', which is representative of the fact that many of the contributing services work predominantly with high-risk clients. In the UK, a designation of 'high-risk' is predominantly made in response to a client achieving a certain threshold on a version of the Domestic Abuse, Stalking and Honour-Based Violence (DASH) checklist. This can either be through achieving an affirmative score in response to questions (most commonly 14), or through a combination of said ticks and an overall professional assessment by the professional completing the DASH. The DASH model is a framework implemented across all police services in the UK that requires police to use a common checklist when attending domestic abuse reports in order to identify, assess and manage risk in domestic abuse cases (Richards, 2009-2016). Other versions of the DASH exist, though they are similar (Safelives, 2015). It contains questions about the current abusive experience (i.e., nature of abuse, injury, feelings of fear etc.), outcomes and responses to abuse (i.e., termination of relationship), children/dependents, domestic violence history, and information about the abuser(s). The guidance in these documents was also used by professionals to inform their professional

judgements of what types of abuse the client is suffering and to classify these accordingly. For other variables, such as mental health issues, a combination of professional assessment and specific reporting by the client was utilised to make a judgement as to whether the client is suffering from issues in this area (formal mental health assessment tools were not routinely utilised). The data gathering process transferred from a paper questionnaire to an online system in 2015.

Preparation of Sample

The initial sample consisted of N = 64,111 cases presenting to services between 2007 and 2017. For the purposes of the present study, several exclusion criteria were applied in order to create a data set detailing cases of men and women who had experienced abuse from opposite-sex intimate partners[8]. First, any cases involving familial violence were excluded (n = 4,915), along with any cases where the relationship of the perpetrator to victim was 'other' (n = 227), unknown (n = 42), or missing (n = 323). Second, clients identifying as intersex or missing data for client gender (n = 777) were excluded. Third, clients recording that their identified gender was different to that assigned at birth (i.e., transgender, n = 137), clients who didn't know whether they were transgender (n = 529), and missing data for this variable (n = 680) were excluded. Fourth, participants identifying as Bisexual (n = 513), Gay (male, n = 163), Lesbian (n = 261), those who did not know or disclose (n = 1033) and missing sexual orientation data (n = 527), were excluded. Fifth, perpetrators identified as intersex (n =3) and missing data (n = 17,576), along with perpetrators identified as transgender (n = 171), who did not know if they were transgender (n = 690), and missing perpetrator data for identification as transgender (n = 250) were excluded. Sixth, cross tabs were generated for client and perpetrator gender using remaining cases. Two hundred and sixty men (0.7%) and

[8] Such exclusions were necessary to allow for the appropriate application of literature pertaining to men's' and women's' experiences of abuse within opposite-sex relationships. However, forthcoming analyses will detail and explore cases involving familial abuse and abuse towards LGBTQ+ individuals.

160 women (0.5%) identified a same-sex primary perpetrator and were thus also excluded. Finally, participants aged under 16 years (N = 26) and those whose age was missing (n = 33) were excluded. This resulted in a final sample of N = 34,815 cases (858 men and 33,957 women).

Analytic Plan

Several focused areas of analysis are outlined below, split into demographic characteristics, routes of referral into service, context of abuse, reported abuse types, and outcomes and risk factors of abuse. Within each of these areas (and respective tables), descriptive data is first presented, followed by relevant inferential analysis assessing differences between male and female victims. For continuous data (i.e., measurement scores), independent sample *t*-tests were conducted, with significant results showing that one group scored higher/lower on a particular measure.

For categorical data (i.e., with a yes/no outcome) binary logistic regressions were conducted. The reference category was always the group showing the lower frequency of the two (as indicated below tables) with significant odds ratios suggesting a higher probability of the presence of a particular case characteristic or factor for the last category. Some questions allowed clients to provide multiple selections (additional vulnerability and employment status) or were simple multiple-choice questions (i.e., with more than just a yes/no option). For these variables, additional dummy variables (1 = yes, 0 = no) were created for each selectable option to allow for inferential analysis (and options such as 'Don't Know' were recoded as missing data).

In terms of interpretation, it is important to recognise the difference between statistical and clinical/meaningful significance. Paquin (1983) advised that "by adding an index of magnitude of effect to the reporting of significance levels, the clinical researcher avoids the possibility of misleading conclusions" (p. 40). As "[v]irtually any study can be

made to show significant results if one uses enough subjects, regardless of how nonsensical the content may be" (Hayes, 1963, p.326). For this reason, Cohen (1962) encouraged the use of effect sizes where small effect sizes (d = .2) *would not* be readily perceptible to an observer; medium differences (d = .5) would be large enough to be noticeable to someone looking for the difference; and a large effect size (d => .8) would be "so obvious as to virtually render a statistical test superfluous" (p. 150). Therefore, in the current analysis with a dataset spanning thousands of cases it is possible to find highly significant differences with very small effect sizes. For effect sizes to interpret *t*-test analysis, Cohen's d is appropriate. In terms of interpreting the clinical significance of the odds ratios (OR), Chen, Cohen and Chen (2010) suggest that authors could interpret OR by relating it to differences in a normal standard deviate calculated from the respective probabilities being compared. Therefore, where OR justify this, effect sizes will be calculated using the Chen et al. (2010) method. Where differences are highly significant but very small these are noted in the tables but will not be discussed in the results or discussion as the effects are likely to be clinically meaningless.

Results

Demographic Data

Table 1 details demographic client data for the whole sample and separated for men and women. The mean age for the whole sample was 33 years old with men being significantly older than women, t (34813) = 22.55, p < .001 (on average eight and a half years older, d = .71), although the age ranges were very similar. Ninety percent of the clients identified as White with the remaining 10% identifying from a wide range of different ethnic backgrounds which suggests White clients are overrepresented in terms of the 2011 United Kingdom Census (though this may have varied for individual services based on region and the local population).

Referral into Service

Table 2 provides data on client referral routes and characteristics. Around 40% of clients were referred from the police, with the next most common route being self-referral (~20%). Descriptive statistics appear to indicate that referral routes were broadly similar for men and women, although women were almost twice as likely as men to be referred through Multi-Agency Risk Assessment Conference (MARAC[9]) and Child/Youth Protection Services (CYPS) routes although the percentages were small as was the effect size (d = .25 and d = .31 respectively). Clients had an average of between 11 and 12 ticks on the DASH, and although women had a significantly higher number of ticks than men the difference is small (d = .28). Around half of clients were deemed as high-risk and met the threshold to be assessed at a MARAC. Women were more significantly likely than men to meet both criteria (d = .22), but again this is based at least in part on DASH scores. Women were significantly more likely than men to require an interpreter (d = .34), and having no recourse to public funds[10], and needing to apply for indefinite leave to remain[11] were rare.

Context of Abuse

Table 3 provides data on the context in which abuse is occurring for the whole sample and as separated by gender. Around 13% of the sample were recorded as having at least one additional vulnerability/need. Men were almost twice as likely (23%) as women (13%) to be recorded as having vulnerabilities (physical d = .34; learning d = .34; Other d = .19), with men significantly more likely than women to have this recorded across a number of specific vulnerabilities. Over half of clients identified themselves as unemployed, with inferential

[9] In the UK, the Multi-Agency Risk Assessment Conference (MARAC) is a monthly risk management meeting where professionals from various organisations and/or services share information on high-risk cases of domestic violence and abuse and put in place a risk management plan.
[10] When granted a residence permit in the UK, it may include the condition that the individual has no recourse to public funds – meaning that they will not be able to claim most benefits, tax credits or housing assistance that are paid by the state.
[11] Indefinite leave to remain (ILR) or permanent residency (PR) is an immigration status granted to a person who does not hold the right of abode in the United Kingdom (UK), but who has been admitted to the UK without any time limit on their stay and who is free to take up employment, engage in business, self-employment, or study. When indefinite leave is granted to persons outside the United Kingdom it is known as indefinite leave to enter (ILE).

analysis revealing that men were significantly more likely to be in paid employment or retired than women, and women significantly more likely to be in education/training or not employed than men (d = .83 and .31 respectively). As such, most participants said that they were either struggling or managing financially, rather than comfortable, with men significantly more likely than women to report being comfortable or managing regular treats, and women significantly more likely to say they were just managing essentials. Approximately two thirds of participants reported children regularly visiting or living in the home, with women significantly more likely to report children in the home than men, and 7% of women were pregnant at the time of presentation. Around one third of clients reported CYPS involvement of some kind, with women significantly more likely than men to report some kind of involvement (d = .12), presumably as a function of the greater likelihood of children in the homes of women rather than men (as indicated by Chi Square analysis showing that CYPS involvement was more likely in homes with resident/visiting children, χ^2 (1) = 2013.33, $p < .001$).

Around two thirds of clients described their abuser as an ex-intimate partner, interestingly, men were more likely (43%) to identify their abuser as a current intimate partner than women (30%; d = .28). Just over half of abusers had a criminal record and approximately two thirds were described as being abusive in other contexts (with women significantly more likely to identify both these characteristics in their abusers than men, d = .34 for both). As a whole sample, most clients were recorded as not living with their abusive partner; however, this was significantly more likely for women than men (d = .34). Most clients identified a single primary perpetrator, and there was a low percentage of cases involving a risk of forced marriage or honour-based violence (though women were more at risk from HBV than men d = .34). Interestingly, whilst men and women showed no differences in the amount of previous abuse suffered, men were significantly more likely than

women to report having experienced at least one form of abuse previously but this effect was negligible (d = .12).

Reported Abuse Type

Tables 4 and 5 provide descriptive statistics regarding the occurrence of abuse, as well as changes in severity and frequency, over the previous three months for clients. When examining occurrence (see Table 4), physical, harassment/stalking and jealous/controlling abuse followed similar patterns, with approximately one third of clients describing the incidence as high, whilst another third stated that this type of abuse had not occurred. The lowest frequencies were for sexual abuse, with three quarters of clients reporting 'none'. Reporting across all types of abuse was broadly similar for male and female clients, however chi square analyses revealed that variations were significant. For physical abuse, a similar number of men and women were recorded as having 'high' levels, with men showing significantly higher frequencies for 'moderate' and 'standard' abuse, and women for 'none' (χ^2 (3) = 104.77, p < .001). For both sexual abuse and harassment/staking, women had significantly higher frequencies for 'high', similar frequencies were given for 'moderate' and 'standard', and men had significantly higher frequencies for 'none' (χ^2 (3) = 41.05, p < .001 and χ^2 (3) = 35.20, p < .001 respectively). Finally, for jealous/controlling abuse, women showed significantly higher frequencies for 'high', men and women were similar for 'moderate' and 'none', and men had significantly higher frequencies for 'standard' (χ^2 (3) = 54.43, p < .001).

When asked about escalation in severity and frequency for abuse types (see Table 5), interesting patterns emerged. For physical abuse, approximately one third of clients were recorded as the abuse getting 'worse', with around 15% of clients describing this abuse as 'unchanged' or 'reduced'. No significant differences were found between men and women in these patterns. For harassment/stalking and jealous/controlling abuse, again, approximately

one third were recorded as this abuse as getting 'worse', and approximately 10-15% said it had reduced. However, more clients described these types of abuse as 'unchanged' than for physical abuse. Chi square analysis revealed significant differences between men and women in their reported frequencies for severity, with significantly higher frequencies found for women in the 'worse' category, and significantly high frequencies for men in the 'unchanged' category for both behaviour types (χ^2 (2) = 14.62, $p < .001$ and χ^2 (2) = 16.63, $p < .001$ respectively; no differences were found for 'unchanged'). These patterns were mirrored for frequency (χ^2 (2) = 12.66, $p < .01$ and χ^2 (2) = 15.47, $p < .001$). Finally, for sexual abuse, due to its low occurrence, less than 10% of clients described this abuse as getting 'worse' or 'reducing', with approximately 13% stating it was unchanged (no differences were found between men and women).

Table 6 provides further information regarding the occurrence and nature of the abuse. Specifically, approximately two thirds of clients had experienced some form of physical or harassment/stalking abuse in the last three months (regardless of severity). This was higher for jealous/controlling behaviours (approx. 80%) and lower for sexual abuse (approx. 20%). Men were significantly more likely than women to have physical abuse recorded (d = .22), with women significantly more likely to report sexual abuse (d = .34) and harassment/stalking (d = .16) although in the latter case the difference is negligible. No differences were found in the frequency of reported jealous/controlling behaviours. Most cases were current (approx. 90%), and men were more likely to report current cases than women, (d = .12) although in the latter case the difference is negligible. The average length of abuse was just over five years, with no differences found between men and women.

Outcomes of Abuse and Risk Factors

Approximately three quarters of clients had attempted to leave their abuser in the previous 12 months, with women significantly more likely than men (d = .31) to have made

at least one attempt (see Table 7). Just under 20% of clients had made a trip to an Accident and Emergency (A&E) department (as a result of their abuse), with no differences found for men and women. Three quarters had made a call to the police, and although women were significantly more likely than men to have made at least one call (d =.12) the effect was very small, and just under 70% of clients had been to their general practitioner (GP; for any reason) or accessed a specialist domestic violence service, with women again more likely to have made at least one visit, but again with a very small effect size (d = .09).

When assessing clients reports of broader issues, consistent patterns emerged. For example, most participants reported not having issues with drugs or alcohol, although of those that did, men were significantly more likely to report this (d = .25 and d = .12). Of those with drug/alcohol issues, most (~75%) accessed an appropriate support service. Many more clients (~40%) reported issues with their mental health with women significantly more likely to report this than men (d = .09). Furthermore, approximately 15% of clients reported thinking about or attempting suicide and engaging in self-harm and, whilst no differences were found between men and women for suicide ideation, women were significantly more likely to report they had self-harmed than men (d = .31). Finally, when asked to rate their physical and mental health overall, clients gave an average rating of seven and six out of ten respectively, with men reporting significantly worse physical health (with a negligible effect size, d = .08).

Discussion

This study sought to explore the demographic characteristics, reported abuse context and type, and outcomes of heterosexual female and male service users accessing specialist DVA services in the UK between 2007 and 2017. This is the first study to utilise such large-scale data, amassed over several years from several providers to explore these areas of interest in relation to both female and male victims within the same dataset. Importantly,

whilst data showed that the overwhelmingly majority of service users were women, many of the factors assessed carried similar risk probabilities for men and women. Moreover, although several factors had a higher probability of occurrence for either male or female clients, few of these were large enough to be clinically significant, thus suggesting a general lack of gender-specific risk factors. Such findings demonstrate the utility of conducting comparative analyses which control for frequency of presentation at services and provide important avenues for the creation of appropriate and inclusive provision for abused men and women.

Frequency of Presentation

The overwhelming majority of service users were female (97.5%). This contrasts with figures from both the UK Office for National Statistics (ONS) which suggest that approximately one third of victims are male (ONS, 2019), and UK police figures which show at least 20% of victims are men (The Mankind Initiative, 2020). Indeed, though the academic literature is still fraught with debate regarding the prevalence of male and female victims, with some researchers suggesting that men and women are equally likely to be victims of DVA in Northern European nations (e.g., Archer, 2006), and others suggesting that women are more frequently the target of violence, especially that which is repeated and prolonged (e.g., Hester, 2009), and whilst there is inevitable nuance available within various data sets (i.e., repeat abuse, abuse type etc), the figures in this sample appear extremely skewed. The proportion of female victims in the current dataset appears closest to Multi-Agency Risk Assessment Conferences (which only assess high-risk cases) which place the figure at around 95% (Safelives, 2019a), and it may well be that the figures in the current sample are reflective of the fact that most agencies providing data were originally (and may well continue to be) set up specifically for high-risk, female clients. The figures from this study therefore likely reflect a significant under-representation of male victims accessing services

(particularly those working with high-risk clients) as compared to their existence in the population at large, and thus support previous research suggesting that there are additional barriers for men to access DVA services (e.g., Huntley et al., 2019), and that the sector is largely oriented towards female victims (Hester et al., 2012).

Similarly, the proportion of non-White British victims suggests that DVA services in their current form are not as accessible to Black, Asian, and Minority Ethnic (BAME) victims or victims from outside of England and Wales. Eighty-seven percent were from white British backgrounds, 3% from other White backgrounds, with only 10% of victims not identifying as White. According to the 2011 census, 14% of the population in England and Wales was BAME and this is likely to be a considerable underestimate of the current population as comparing figures from 2001 to 2011, the percentage of the population of England and Wales that was White British decreased from 87.4% to 80.5%, and the percentage of the population from a Black African background doubled from 0.9% in 2001 to 1.8% in 2011. This is consistent with previous research that found additional barriers to service provision exist for black and ethnic minority women (e.g., Kulwicki et al., 2010; Yoshioka & Choi, 2005), and providing new evidence in relation to BAME male victims. Crime Figures for England and Wales also suggest that BAME status may increase the risk of domestic abuse (Office for National Statistics, 2019), thus suggesting the need for further exploration into BAME access to specialist DVA services. Though it be noted that data from individual services may have been more representative of the ethnic profile of the local population.

Shared Characteristics Between Male and Female Victims

Several case characteristics were found to have a similar probability of occurrence for male and female victims. Women and men shared a similar referral route to services (most commonly via the police or self-referral) and were equally likely to report an escalation in the severity and frequency of physical abuse, harassment/stalking and jealousy/controlling

behaviour. They were also equally likely to report experiencing jealousy/controlling behaviour, as seen within previous literature where both individual studies (Bates et al., 2014) and larger scale reviews (Carney & Barner, 2012) have demonstrated men's and women's equitable experiences of this type of abuse. Interestingly, both women and men were equally likely to have visited A&E as a result of DVA injuries, had similar levels of suicidal ideation and rated their mental health as similarly suffering (see below for further discussion relating to mental health needs and self-harm). Furthermore, there were no differences found in the average length for experiencing abuse (5 years), or in levels of previous abuse. These results support previous separate examinations of mental health in female (Ferrari et al., 2016) and male victims (Hines & Douglas, 2011, 2015, 2016); and go against evidence that female perpetrated violence towards men is less serious, or has less serious consequences (Thureau et al., 2015). As such, whilst it must be noted that this result could be a function of the fact that all clients were engaging with services designed for high-risk individuals, practitioners would nonetheless benefit from recognising parity of impact.

Gender-Specific Case Characteristics and Risk Factors

Importantly, this is the first study to highlight that some case characteristics appear to be significantly more likely in one population than the other, whilst controlling for overall sub-sample size. For example, whilst referral routes were similar for men and women, women were more likely to come through particular avenues – such as MARACs and other specialist services – suggesting they may be more visible to other services. Women were also more likely to meet the MARAC threshold as high-risk, and achieved a higher score on the DASH form; results which will add fuel to the debate around effective assessment of risk in victims of DVA, and the reliability of the DASH itself (Almond et al., 2019; Turner et al., 2019). Indeed, previous research has found that the administration of the DASH is inconsistent (Ariza et al., 2016), and questions have been raised about whether additional

validation is needed with male samples (Turner et al., 2019). Arguably further investigation is needed to explore whether men in cases assessed are genuinely lower risk, or whether they are simply evaluated as such because they are men, and therefore have to meet higher implicit thresholds (Bates et al., 2019). For example, research consistently finds that men are blamed more for their victimisation and their abuse experience is seen as less severe than women (Erickson et al., 2017; Wilchek-Avaid et al., 2018), which suggests that there may be systemic bias to be addressed.

Turning to abuse context, men were more likely than women to report having an additional vulnerability/need (e.g., physical, learning, visual or other). This may suggest that disabled men are more visible to DVA services, that men with additional vulnerabilities are more easily accepted as victims by services, and/or that men with vulnerabilities are more susceptible to victimisation. Men were also significantly older than women, with the average age of men in this sample being 42.29 (compared to 33.69 for women); similar to data from organisations in the UK supporting male victims of IPV which indicate the average age of men who called their helpline was 42 (Mankind Initiative, 2020). This may indicate that men take longer to report their abuse (Hine et al., 2021), though this is not supported by the length of abuse findings from this study. Men were also more likely to report having suffered at least one form of abuse previously. Though it was not possible from this data to establish when this previous abuse occurred, this finding suggests that the experiences of Adverse Childhood Experiences (ACEs; Felitti et al., 1998) may be as relevant to male victims of DVA as they are to female victims. Previous literature has typically focused on women's vulnerabilities in this area (Whitfield et al., 2003) or where they are linked to men's perpetration of DVA (Mair et al., 2012); this finding suggests that male victims may have similar vulnerabilities and thus require specialist trauma-informed support that goes beyond support for DVA victimisation.

A particularly salient characteristic for cases involving women is the caring responsibility they have for children; two thirds of all participants in the current study had children, but, compared to men, women were more likely to have the children in the home, and more likely to have contact with children's services. Having children may make women more visible to specialist services and may encourage women to make initial contact with other bodies (e.g., police). In contrast, other characteristics suggest that men may be less visible to services; for example, men in the current study were more likely to identify their *current* partner as their perpetrator and to still be living with them compared to women and were less likely than women to have attempted to leave. Both findings indicate men are more likely to be continuing to endure abuse, and perhaps be less likely to come to the attention of services as a result of leaving their partner. Moreover, some of the services providing data for this study involved refuge provision which is still predominantly oriented towards women in the UK; another factor that may therefore be partly responsible for the greater likelihood of men's ongoing residence with their abusive partner and lack of visibility to services. This is an important factor to consider in both attempting to engage men, and in supporting them when they approach. Indeed, these findings support previous assertions that many men do not seek help due to not identifying as victims themselves and also a lack of trust in the service system available (Machado et al., 2016). Moreover, just as children may make female victims more visible to services, the opposite may be true for men. Indeed, Hines and Douglas (2010a) found concerns for the children (88.9%) and fear of losing contact with children (67.5%) as two of the key reasons men had reported for why they were still in abusive relationships, and had not disclosed their abuse.

In terms of reported abuse types, men were more likely to report experiencing physical abuse, whereas women were more likely to report sexual abuse and stalking/harassment. These findings support literature that exists that demonstrates women's

propensity to be as physically aggressive if not more so than men to their opposite-sex partners (Archer, 2000), as well as the higher rates of victimisation reported by women in terms of sexual aggression (Smith et al., 2017). Men's reporting of physical abuse as higher (in the current study) may also reflect men's perceptions of severity of abuse, and so the need for service intervention, may rest on the idea of having physical injuries.

Outcomes related to help-seeking also showed differences, with women more likely to have called the police and more likely to have accessed a specialist DVA service compared to men, findings supported by Crime Survey of England and Wales (CSEW[12]) data suggesting that women are more likely to tell someone about their abuse (Office for National Statistics, 2019). Such results suggest that, although there are still barriers in place that prevent women from asking for help, these are lower than for men where they may additionally include fearing being laughed at or not believed (Bates, 2019b), challenges to masculinity (Hine, Bates, & Wallace, 2020; Huntley et al., 2019), and the fear of the losing their children (Taylor et al., 2020). Indeed, research suggests that men's experiences of help-seeking are not always positive with DVA services, often being rated as least helpful/positive sources of support (Douglas & Hines, 2011), or even describing being 'revictimized' by these services and systems (Hines et al., 2007, p.69).

Data showed that there were also gender specific experiences in outcomes specifically relating to the abuse; men rated their physical health to be lower than women did, and women reported more self-harm. The detrimental impact of DVA is seen within the wider literature with research demonstrating a wide variety of adverse physical (Hawcroft et al., 2019; Hines & Douglas, 2016) and mental health outcomes (Afifi et al., 2009; Lagdon et al., 2014; Lysova et al., 2019; Thomas et al., 2019), with these results suggesting that health provision

[12] The Crime Survey for England and Wales has measured crime since 1981 by asking members of the public about their experiences of crime over the last 12 months. Used alongside police recorded crime data it is a valuable source of information for the government about the extent and nature of crime in England and Wales.

should take into account gender-specific risks (though, as with additional vulnerabilities, this could also be linked to men being significantly older than women in the current sample). Men also showed a higher likelihood (than women) of externalising their experience more through alcohol and drugs, with women demonstrating a higher likelihood (than men) of reporting mental health symptoms. Previous research has highlighted that victimisation across all types of IPV is associated with increased substance use for men (as opposed to only controlling behaviours for women; Coker et al., 2002), and support conclusions from this study that men may be masking mental health and/or physical health problems through self-medicalisation of alcohol and drugs and may need targeted substance use support when approaching specialist DVA services. Though subject to some variation, the services providing data for this study, and indeed most DVA services in the UK, would not disbar an individual from engaging if they were also identified as having a substance misuse issue, as long as this did not compromise the safety of all involved. However, based on these parameters it can be assumed that in most instances, the substance misuse identified would be relatively mild, and there is therefore a need for a holistic approach to treatment of co-occurring DVA and (more extreme) substance misuse issues by relevant services.

It is important to note however that almost all of the differences described above had small or even negligible effect sizes, suggesting that they are not clinically significant, but more likely the result of an extremely large sample size. Results therefore suggest more similarity than difference between male and female clients, and the findings above should thus be interpreted and applied with caution.

Implications

Implications of the findings detailed above are twofold. First, results from this study demonstrate that DVA services are less accessible to men than women and to BAME victims as opposed to those of White ethnicity. Additionally, the mean age of victims suggests that

DVA services are perceived as more accessible to older victims, whereas crime statistics and victim surveys suggest younger people are more at risk. Second, when comparing females and males, increased risk and vulnerability factors present for both groups. It also appears that male and female victims may also manage their distress differently, with men being more likely to use alcohol or drugs, and women more likely to self-harm or identify as having mental health issues. These different expressions of distress highlight the importance in ensuring that services recognise group-specific differences in experience, and how reactions to abuse may be representative of broader gender role stereotypes regarding expression of emotion and processing of trauma. Such an approach would ultimately allow service providers to approach clients in a more inclusive way, thus ensuring that risk and need is calculated appropriately. However, due to the small size of many of these 'differences', it is argued that a 'base' service should be available to all groups, with options for tailored support for men and women, which allow services to acknowledge and cater to gender-specific factors, should they arise. Indeed, this point goes beyond simply gender, and the option of tailored support should be available within services to cater to a variety of individual and group needs across various demographic factors (e.g., age, ethnicity).

Such messages are reflected in the second implication, men's overall engagement with services. Though analysis controlling for overall presentation was available and conducted, it is still a significant concern that men constituted a small minority of the sample (2.5%). As outlined above, there is considerable debate surrounding the proportion of victims that are male and female, but even when comparing to conservative estimates (e.g., 20% victims who report to police are male) this appears to still be a troublingly low percentage. It is therefore imperative that results from the current study are utilised, along with future research, to understand how best to engage men and help them to overcome, or indeed to remove, barriers to service engagement. For example, many of the services contributing to

this sample *only* work with women, and the sector overall is still seen as a 'female domain' (Hester et al., 2012). However, if services were to appear and genuinely become more available and appropriate for men, then more men would be likely to approach, and thus break the negative feedback mechanism which results in men being under-represented in victimisation figures. Indeed, the more men are able to approach and access services, then the better representation they will have in both numbers and understanding of their gender-specific experiences – this will then encourage more men to engage and so we should see this engagement figure rise (thus enabling the proportionally distribution of resources and funding to services). This can only be beneficial, especially when considering evidence which suggests that when men engage with and have positive experiences in their help-seeking, it can reduce some of the adverse outcomes associated with DVA (e.g., Douglas & Hines, 2011).

Indeed, the extremely low proportion of male victims adds further fuel to discussions surrounding the appropriateness of governmental frameworks in relation to the DVA sector. Specifically, within England and Wales, DVA legislation is currently under the umbrella legislation of the Violence Against Women and Girls Strategy (Crown Prosecution Service, 2020b), as is the prosecutorial guidance on working with the range of types of abuses that fall under this strategy including partner violence, forced marriage, rape and sexual offenses and child abuse. This strategy "…provides an overarching framework for crimes identified as being primarily committed, but not exclusively, by men, against women, within a context of power and control" (Crown Prosecution Service, 2020a), and they highlight the majority of offences under VAWG are experienced by women. Whilst the guidelines are gender neutral and are to be applied to victims of crime similarly regardless of their gender, being framed under such a legislative classification is likely to influence the ways in which service providers engage supporting victims, as well as how service users perceive this support.

Limitations

Whilst large datasets produce significant statistical power, they often hide important nuance. In this study, whilst we made important and necessary case exclusions, we still treated all male and female victims of opposite-sex abuse as homogenous groups, which may mask important variation in the demographic or experiential characteristics of each. Moreover, it has been noted that many of the significant differences observed in this study have small effect sizes, potentially as the result of a large sample size, instead suggesting greater similarity than dissimilarity between the two groups. Second, there are significant caveats relating the method in which the data for this study was collected. Put simply the accuracy of the data relies on the completion of forms by caseworkers and other professionals, with completion accuracy and frequency unavoidably varying across and within services. Such practices arguably also introduce additional issues including secondary interpretation of meaning and experience, and social desirability pressures (i.e., clients responding differently to a caseworker than if self-reporting). However, it is also arguable that it would be inappropriate to expect clients to fill out lengthy and sometimes complicated forms independently, and that this represents the best version of the data available.

Third, gaps in understanding remain in relation to service user outcomes upon their exit from services, and thus the extent and effectiveness of the service provision they were offered and engaged with. However, whilst beyond the scope of this paper, this analysis is presented in a complementary 'Part II' manuscript (see Hine, Bates, Graham-Kevan et al., 2020). Similarly, LGBTQ+ service users were excluded as members of this community may experience additional barriers in help-seeking for DVA (Laskey & Bolam, 2019), and so further group-specific findings may be revealed when examining this population. Again, whilst beyond the scope of this manuscript, analyses of data pertaining to LGBTQ+ service users are upcoming.

Conclusion

The findings of the current study provide novel and valuable insight into the nature of service engagement for both male and female victims of DVA, utilising the data drawn from the same large-scale, national sample. As such, in moving away from focusing on the objective numbers of men and women presenting to service and instead exploring the *relative* risk associated with each, results from the current study provide critical insight into both men and women's experiences of abuse. Nonetheless, findings also revealed notable differences in frequency of service access and engagement across different victim groups (e.g., male, BAME victims and younger victims), and thus highlight the need to understand potential challenges to accessing service provision these groups endure.

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Tables

Table 1. Client Demographic Information

	Whole Sample (N = 34,815)	Men (N = 858)	Women (N = 33,957)
Age			
Min	16	16	16
Max	97	92	97
Mean	33.90	42.29	33.69
SD	11.12	13.21	10.98
		N (%)	
Ethnicity			
White/White British	31, 252 (89.77)	796 (92.77)	30, 456 (89.69)
Asian/Asian British	1899 (5.45)	32 (3.73)	1867 (5.49)
Arab/Arab British	138 (0.39)	5 (0.58)	133 (0.39)
Black/Black British	636 (1.83)	13 (1.52)	623 (1.83)
Dual heritage	390 (1.12)	4 (0.47)	386 (1.14)
Any other ethnic background	209 (0.60)	0 (0.00)	52 (0.15)
Not disclosed	52 (0.15)	2 (0.23)	82 (0.24)
Don't Know	84 (0.24)	4 (0.47)	151 (0.44)
Missing	155	4	151

Table 2. Descriptives and Inferential Comparisons for Service Referral Routes and Characteristics

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	Effect Size (*d*)
Referral Route											
Police[±]	13688	39.3	356	41.5	13332	39.3	.09 (.07)	1.74	1.09	[0.96, 1.26]	
Multi-Agency Risk Assessment Conference (MARAC)	1446	4.2	22	2.6	1424	4.2	.51 (.22)*	5.46	1.66	[1.09, 2.55]	0.25
Self[±]	7927	22.8	218	25.4	7709	22.7	.15 (.08)	3.48	1.16	[0.99, 1.36]	
Health[±]	2743	7.9	84	9.8	2659	7.8	.25 (0.12)	4.41	1.27	[1.02, 1.61]	
Domestic Violence & Abuse (DVA) & Sexual Violence (SV) Services	333	9.6	60	7.0	3273	9.6	.35 (0.14)**	6.69	1.42	[1.09, 1.85]	0.16
Housing[±]	864	2.5	22	2.6	842	2.5	.03 (.22)	0.03	1.04	[0.67, 1.59]	
Children & Youth Protection Services (CYPS)	2899	8.3	40	4.7	2859	8.4	.63 (.16)***	14.98	1.88	[1.37, 2.59]	0.31
Specialist Services[±]	727	2.1	18	2.1	709	2.1	.01 (.24)	0.00	1.01	[0.63, 1.61]	
Other[±]	1188	3.4	38	4.4	1150	3.4	.28 (.17)	2.74	1.32	[0.95, 1.84]	
No. of ticks on DASH	M = 11.69, SD = 4.36		M = 10.56, SD = 4.22		M = 11.72, SD = 4.36				t (32418) = -7.27, p < 0.001		0.28
High-risk?											
Yes	19564	43.8	385	44.9	19179	56.5	.47 (.07)***	45.05	1.59	[1.39, 1.83]	0.22
No	15251	56.2	473	55.1	14778	43.5					
Do they meet MARAC Threshold?											
Yes	17388	50.1	340	39.6	17048	50.2	.43 (.07)***	36.93	1.54	[1.53, 1.77]	0.19
No	17426	49.9	518	60.4	16908	49.8					
Does client need an interpreter?											
Yes	1148	3.3	13	1.5	1135	3.4	.82 (.28)*	8.45	2.26	[1.23, 3.93]	0.34
No	33351	96.7	843	98.5	32508	96.6					
No recourse to public funds											
Yes	1860	5.3	31	3.7	1829	5.5	.41 (.19)*	5.03	1.51	[1.05, 2.17]	0.19
No	32043	94.5	801	96.3	31242	94.5					
Application for indefinite leave to remain needed?											
Yes	764	2.2	11	1.3	753	2.3	.57 (.31)	3.44	1.76	[0.97, 3.21]	
No	33205	97.8	834	98.7	32371	97.7					

Note. *=p<0.05, **=p<0.01, ***=p<0.001

[±] Reference category is women. No symbol indicates reference category is men.

Missing values are only provided for variables where more than 5% of total sample is missing

Table 3. Descriptives and Inferential Comparisons for Reported Abuse Context

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	*d*
Additional Vulnerability											
Physical±	1893	5.7	86	10.2	1807	5.6	.79 (.11)***	57.07	2.21	[0.37, 0.56]	0.34
Learning±	791	2.4	40	4.8	751	2.3	.75 (.15)***	23.63	2.11	[0.35, 0.64]	0.34
Visual±	79	0.2	3	0.4	76	0.2	1.18 (.30)***	15.31	3.26	[0.17, 0.55]	0.55
Hearing±	225	0.7	6	0.7	219	0.7	.42 (.36)	1.37	1.52	[0.32, 1.33]	
Other±	1118	3.3	44	5.2	1074	3.3	.38 (.16)*	5.78	1.46	[0.50, 0.93]	0.19
Multiple±	256	0.8	12	1.4	244	0.7	.65 (.29)*	4.75	1.91	[1.07, 3.43]	0.34
Yes (Any) ±	4362	13.1	191	22.7	4171	12.8	.69 (.08)***	67.79	1.99	[0.43, 0.59]	0.34
No	29028	86.9	651	77.3	28377	87.2					
Employment											
Yes – paid±	11237	32.6	403	47.5	10834	32.2	.62 (.07)***	79.89	1.86	[0.47, 0.62]	0.31
Yes – voluntary	169	0.5	2	0.2	167	0.5	.91 (.71)	1.64	2.49	[0.62, 10.02]	0.34
Yes – Education/Training	1422	4.1	8	0.9	1414	4.2	1.60 (.36)***	20.17	4.95	[2.46, 9.95]	0.83
No - Retired±	345	1.0	24	2.8	321	1.0	1.35 (.22)***	38.98	3.86	[0.17, 0.39]	0.71
No	20334	59.0	381	44.9	19953	59.4	.57 (.07)***	67.43	1.77	[1.55, 2.03]	0.28
Don't Know±	939	2.7	31	3.7	908	2.7	.37 (.18)*	4.22	1.44	[0.49, 0.98]	0.16
Financial Situation[1]											
Struggling to pay for essentials	3409	23.2	96	22.9	3313	23.2	.02 (.12)	.03	1.02	[0.81, 1.28]	
Managing to pay for essentials – nothing left	6114	41.7	147	35.1	5967	41.9	.29 (.10)**	7.67	1.33	[1.09, 1.63]	0.12
Managing to buy occasional treat or save±	3672	25.0	117	27.9	3555	24.9	.15 (.11)	1.92	1.66	[0.69, 1.07]	
Managing regular treats and saving±	643	4.4	28	6.7	615	4.3	.46 (.20)*	5.35	1.59	[0.43, 0.93]	0.22
Comfortably managing – don't have to worry±	831	5.7	31	7.4	800	5.6	.29 (.19)	2.41	1.34	[0.51, 1.08]	0.12
Are there children in household or who visit regularly?											
Yes	24187	69.5	454	52.9	23733	69.9	.73 (.07)***	109.23	2.07	[1.80, 2.37]	0.34
No	10628	30.5	404	47.1	10224	30.1					
How many children live in the household full time?[2]											
None	1760	7.2	102	22.7	1658	6.9					
1-2	17422	71.2	274	61.0	17148	71.3					
3-4	4747	19.4	66	14.7	4681	19.5					
4 or more	557	2.3	7	1.6	550	2.3					
Is the client pregnant?											
Yes					2395	7.1					
No	N/A	N/A	N/A	N/A	31140	91.9					
Don't Know					356	1.0					

Note. *=p<0.05, **=p<0.01, ***=p<0.001

± Reference category is women. No symbol indicates reference category is men.

[1]57.9% missing data for the whole sample (51% for men, 58% for women)

[2]29.7% missing data for the whole sample (47.7 for men, 29.2 for women)

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	*d*
Is there Child/Youth Protection Services (CYPS) Involvement?[1]											
Yes	12126	38.9	250	33.5	11876	39.0	.24 (.08)**	9.19	1.27	[1.09, 1.48]	0.12
No	19070	61.1	496	66.5	18574	61.0					
Perpetrator Relationship to client											
Intimate Partner	10572	30.4	369	43.0	10203	30.0	.56 (.07)***	64.87	1.76	[0.49, 0.65]	0.28
Ex-intimate Partner	23453	67.4	470	54.8	22983	67.7	.55 (.07)***	61.94	1.73	[1.51, 1.98]	0.25
Intermittent Intimate Partner	790	2.3	19	2.2	771	2.3	.03 (.24)	0.01	1.03	[0.65, 1.62]	
Does perpetrator have a criminal record?											
Yes	18922	54.8	284	33.3	18638	55.3	.91 (.07)***	152.57	2.48	[2.15, 2.86]	0.34
No	15605	45.2	568	66.7	15037	44.7					
Has perpetrator been abusive in other contexts?[2]											
Yes	18922	54.8	273	50.2	15693	69.4	.81 (.09)***	86.71	2.25	[1.89, 2.67]	0.34
No	15605	45.2	271	49.8	6932	30.6					
Living Arrangement											
Living Together	7073	20.3	300	35.0	6773	19.9	.77 (.07)***	110.36	2.15	[0.40, 0.54]	0.34
Living Together Intermittently	1187	3.4	32	3.7	1155	3.4	.09 (.18)	.26	1.09	[0.64, .1.30]	
Not Living Together[±]	26457	76.0	526	61.3	25931	76.4	.73 (.07)***	103.48	2.06	[1.79, 2.37]	0.34
Multiple Perpetrators											
Yes	2589	7.5	53	6.2	2536	7.5	.21 (.14)	2.19	1.24	[0.93, 1.64]	
No	31887	92.5	803	93.8	31084	92.5					
Risk of Forced Marriage											
Yes	217	0.6	3	0.4	214	0.6	.59 (.58)	1.06	1.82	[0.58, 5.70]	
No	34273	99.4	853	99.6	33420	99.4					
Risk of Honour-Based Violence											
Yes	1076	3.1	11	1.3	1065	3.2	.92 (.31)**	9.02	2.49	[1.38, 4.55]	0.34
No	33260	96.9	837	98.7	32423	96.8					
Exposure to previous abuse											
Sum	M = 0.51, SD = 0.69		M = 0.51, SD = 0.54		M = 0.51, SD = .70		*t* (34813) = 0.34, *p* > 0.05				
Yes (any)	14906	42.8	425	49.5	14481	42.6	.28 (.07)***	16.12	1.32	[0.66, 0.87]	0.12
Exposure to previous abuse											

Note. *=*p*<0.05, **=*p*<0.01, ***=*p*<0.001

[±] Reference category is women. No symbol indicates reference category is men.

[1]10.4% missing data (13.1 for men, 10.3 for women)

[2]33.5% missing data (36.6 for men, 33.4 for women)

Table 4. Descriptive statistics for Reported Abuse Type (past 3 months)

	High		Moderate		Standard		None	
	N	%	N	%	N	%	N	%
Physical								
Men	276	32.4	184	21.6	132	15.5	261	30.6
Women	11554	34.3	5217	15.5	2694	8.0	14257	42.3
Whole Sample	11830	34.2	5401	15.6	2826	8.2	14518	42.0
Sexual								
Men	21	2.5	53	6.4	62	7.5	693	83.6
Women	2784	8.5	2389	7.3	2527	7.7	24969	76.4
Whole Sample	2805	8.4	2442	7.3	2589	7.7	25662	76.6
Harassment/Stalking								
Men	214	25.4	193	22.9	114	13.5	323	38.3
Women	11601	34.7	7279	21.8	4119	12.3	10445	31.2
Whole Sample	11815	34.5	7472	21.8	4233	12.3	10768	31.4
Jealous/Controlling								
Men	261	30.8	245	28.9	174	20.5	168	19.8
Women	14195	42.1	8785	26.1	4730	14.0	5979	17.7
Whole Sample	14456	41.9	9030	26.1	4904	14.2	6147	17.8

Table 5. Descriptive Statistics for Abuse Escalation – Severity and Frequency

	Worse		Unchanged		Reduced		N/A	
	N	%	N	%	N	%	N	%
Severity								
Physical								
Men	314	37.1	162	19.1	160	18.9	210	24.8
Women	11479	34.4	4921	14.8	5264	15.8	11697	35.1
Whole Sample	11793	34.5	5083	14.9	5424	15.9	11907	34.8
Sexual								
Men	42	5.1	99	12.0	58	7.0	628	75.9
Women	2783	8.5	4381	13.4	2975	9.1	22647	69.1
Whole Sample	2825	8.4	4480	13.3	3033	9.0	23275	69.2
Harassment/Stalking								
Men	224	26.6	237	28.1	96	11.4	286	33.9
Women	11645	34.8	8652	25.9	3866	11.6	9285	27.8
Whole Sample	11869	34.6	8889	25.9	3962	11.6	9571	27.9
Jealous/Controlling								
Men	274	32.5	307	36.4	122	14.5	141	16.7
Women	13292	39.6	10623	31.7	4661	13.9	4964	14.8
Whole Sample	13566	39.5	10930	31.8	4783	13.9	5105	14.8
Frequency								
Physical								
Men	296	35.1	165	19.6	172	20.4	210	24.9
Women	10813	32.6	5141	15.5	5603	16.9	11634	35.1
Whole Sample	11109	32.6	5306	15.6	5775	17.0	11844	34.8
Sexual								
Men	45	5.5	99	12.0	59	7.2	619	75.3
Women	2689	8.3	4378	13.5	3053	9.4	22373	68.9
Whole Sample	2734	8.2	4477	13.4	3112	9.3	22992	69.0
Harassment/Stalking								
Men	224	26.6	230	27.3	104	12.4	283	33.7
Women	11469	34.4	8458	25.4	4196	12.6	9232	27.7
Whole Sample	11693	34.2	8688	25.4	4300	12.6	9515	27.8
Jealous/Controlling								
Men	272	32.3	303	35.9	127	15.1	141	16.7
Women	13062	39.0	10451	31.2	5028	15.0	4981	14.9
Whole Sample	13334	38.8	10574	31.3	5155	15.0	5122	14.9

Table 6. Descriptives and Inferential Comparisons for Reported Abuse Type and Characteristics

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	*d*
Experiences of Abuse (in last 3 months)											
Physical											
Yes	20057	58.0	592	69.4	19465	57.7	.51 (.08)***	45.67	1.66	[0.52, 0.69]	0.22
No	14518	42.0	261	30.6	14257	42.3					
Sexual											
Yes	7836	23.4	136	16.4	7700	23.6	.45 (.09)***	22.78	1.57	[1.31, 1.89]	0.22
No	25662	76.6	693	83.6	24969	76.4					
Harassment/Stalking											
Yes	23520	68.6	521	61.7	22999	68.8	.31 (.07)***	18.79	1.37	[1.19, 1.57]	0.16
No	10768	30.9	323	38.3	10445	31.2					
Jealous/Controlling											
Yes	28390	82.2	680	80.2	27710	82.3	.14 (.09)	2.40	1.15	[0.97, 1.36]	
No	6147	17.8	168	19.8	5979	17.7					
Is the case…?											
Historical	4021	11.9	76	9.2	3945	12.0	.29 (.12)*	5.88	1.34	[0.59, 0.95]	0.12
Current	29745	88.1	750	90.8	28995	88.0					
Length of abuse (yrs.)	M = 5.36, SD = 12.79		M = 5.86, SD = 7.83		M = 5.35, SD = 12.89			*t* (34721) = 1.16, *p* > 0.05			

Note. *=$p<0.05$, **=$p<0.01$, ***=$p<0.001$

[±] Reference category is women. No symbol indicates reference category is men.

Table 7. Descriptives and Inferential Comparisons for Abuse Outcomes and Risk Factors

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	*d*
Attempts to Leave in last 12 months	M = 1.93, SD = 7.26		M = 1.50, SD = 2.44		M = 1.94, SD = 7.02		*t* (30314) = -1.64, *p* > 0.05				
Has an attempt to leave been made?											
Yes	24095	79.5	496	68.6	23599	79.7	.59 (.08)***	52.29	1.80	[1.54, 2.11]	0.31
No	6221	20.5	227	31.4	5994	20.3					
Visits to Accident & Emergency department (A&E) in last 12 months	M = 0.26, SD = 1.00		M = 0.25, SD = 0.84		M = 0.26, SD = 1.01		*t* (30554) = -.44, *p* > 0.05				
Has a visit to A&E have been made?											
Yes	5745	18.8	126	17.1	5619	18.8	.12 (.09)	1.44	1.13	[0.93, 1.37]	
No	24811	81.2	611	82.9	24200	81.2					
Calls to Police in last 12 months	M = 1.87, SD = 4.28		M = 1.79, SD = 3.49		M = 1.87, SD = 4.29		*t* (32306) = -0.49, *p* > 0.05				
Has a call to the police been made?											
Yes	23981	74.2	548	69.9	23433	74.3	.22 (.08)**	7.84	1.25	[1.07, 1.46]	0.12
No	8327	25.8	236	30.1	8091	25.7					
Visits to General Practitioner (GP) in last 12 months	M = 3.32, SD = 5.97		M = 3.13, SD = 6.13		M = 3.32, SD = 5.97		*t* (26665) = -.80, *p* > 0.05				
Has a visit to the GP been made?											
Yes	18245	68.4	407	62.9	17838	68.5	.21 (.08)*	6.16	1.23	[1.05, 1.45]	0.12
No	8422	31.6	230	36.1	8192	31.5					
Visits to Specialist DV Service in last 12 months	M = 0.32, SD = 0.90		M = 0.23, SD = 1.15		M = 0.32, SD = 0.89		*t* (30107) = -2.64, *p* < 0.05				0.09
Has a visit to a specialist DV service been made?											
Yes	7366	24.5	114	15.8	7252	24.7	.56 (.10)***	29.19	1.74	[1.43, 2.13]	0.25
No	22743	75.5	607	84.2	22136	75.3					
Problem with drugs?											
Yes	2217	6.6	74	9.1	2143	6.6	.35 (.12)**	7.91	1.41	[0.55, 0.90]	0.16
No	31193	93.4	742	90.9	30451	93.4					
Specialist drugs service accessed?											
Yes	1101	76.4	33	73.3	1068	76.4	.16 (.34)	.23	1.18	[0.60, 2.31]	
No	341	23.6	12	26.7	329	23.6					
Problem with alcohol?											
Yes	3196	9.6	101	12.5	3095	9.5	.29 (.11)**	7.68	1.34	[0.60, 0.92]	0.12
No	30064	90.4	710	87.5	29354	90.5					
Specialist alcohol service accessed?											
Yes	1481	75.6	45	75.0	1436	75.6	.03 (.29)	.01	1.03	[0.57, 1.87]	
No	479	24.4	15	25.0	464	24.4					
Problem with mental health?											
Yes	13346	40.1	290	35.5	13056	40.2	.20 (.07)**	7.30	1.22	[1.06, 1.41]	0.09
No	19915	59.9	526	64.5	19389	59.8					

Note. *=p<0.05, **=p<0.01, ***=p<0.001

[±] Reference category is women. No symbol indicates reference category is men.

	Whole Sample		Men		Women						
	N	%	N	%	N	%	B (SE)	Wald	Odds Ratio	95% CI	*d*
Specialist mental health service accessed?											
Yes	8245	86.4	186	83.8	8059	86.5	.21 (.18)	1.32	1.24	[0.86, 1.78]	
No	1298	13.6	36	16.2	1262	13.5					
Ever planned/attempted suicide?											
Yes	5046	15.6	117	14.6	4929	15.7	.09 (.10)	.70	1.09	[.89, 1.33]	
No	27238	84.4	686	85.4	26552	84.3					
Ever engaged in self-harm?											
Yes	5056	16.2	71	9.2	4985	16.3	.66 (.13)***	27.32	1.93	[1.51, 2.46]	0.31
No	26243	83.8	701	90.8	25542	83.7					
Overall Physical Health rating	M = 7.11, SD = 1.94		M = 6.96, SD = 1.89		M = 7.12, SD = 1.94				t (21302) = -2.17, $p < 0.05$		0.08
Overall Mental Health rating	M = 5.98, SD = 2.02		M = 6.00, SD = 1.82		M = 5.98, SD = 2.03				t (21365) = .19, $p > 0.05$		

Note. *=p<0.05, **=p<0.01, ***=p<0.001

[±] Reference category is women. No symbol indicates reference category is men.