Domestic Violence and Abuse and Hidden Groups

8

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8.1 Introduction

Societies around the world are characterised by diversity and this diversity reflects a wide range of social characteristics, backgrounds and experiences. Despite this widespread diversity, many communities face marginalisation, social exclusion and, subsequently, they can be considered hidden or hard-to-reach (Ahmed and Rogers 2016). These are those communities who are often absent from mainstream discourse, research, policy and practice because of processes of invisibilisation or systemic exclusion that result from practices or structures that uphold systemic exclusion (Wilkerson et al. 2014). In this chapter, attention is given to some of these hard-to-reach communities, who can be invisible in policy, practice and research concerning domestic violence and abuse (DVA). This chapter will enable the reader to see beyond the 'public story' of DVA as it is well established that DVA is a complex global phenomenon affecting a concerningly high number of individuals and families, occurring across cultural, ethnic, religious, age and gender boundaries (WHO 2017). This chapter will explore current understandings about DVA in relation to the following groups of people who can be considered to be hard-to-reach within the context of DVA. This includes: lesbian, gay, bisexual, trans and queer (LGBTQ) communities; male victims; women with learning disabilities; black and ethnic minority (BME) communities.

The term hard-to-reach is a contested and ambiguous one (Cook 2002), however, it is frequently used within the fields of health and social care and in relation to health and social inequalities. In this way, hard-to-reach refers to those groups in society who experience distinct barriers to inclusion, participation and access to services (Flanagan and Hancock 2010). In the UK, for example, it is widely recognised that

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cultural and social conditions have resulted in various groups being considered as hard-to-reach, including people who are asylum seekers or refugees, people from black and ethnic minority communities, and people from gender and sexual minority communities. Within the discourse of DVA, there is a dominant 'public story' that promotes the idea that there is a particular type of 'victim-survivor' and a particular type of 'perpetrator'. This public story perpetuates the myth that DVA is a problem of heterosexual male violence against heterosexual females of childbearing age (Donovan and Hester 2014). This has resulted in the exclusion of groups of people who do not easily fit into this typology. There are additional processes in operation which mean that some groups are marginalised, and therefore hidden or hard-to-reach, in the context of DVA. For example, an analysis of DVA as a problem for white populations highlights structural issues, such as gender inequality (Stark 2007), but when turning the lens to BME populations, DVA can be explained as resulting from cultural differences. This is problematic as it can result in othering processes, and the neglect of a focus on DVA within these communities.

8.2 Background: Policy and Practice

Before moving to discuss each hard-to-reach group, it is useful to consider how the policy framework for DVA addresses the issues faced by people who are victim-survivors of DVA and categorised as being from hard-to-reach populations. Policy responses in the UK should be underpinned by a Central Government initiative, the *Ending Violence against Women and Girls Strategy 2016–2020* (EVAWG) (Home Office 2016). This strategy states that all fields of practice should commit to tackling DVA as this is 'everyone's responsibility' (Home Office 2016: 11). The EVAWG strategy has three key target areas which are prevention, early help and increased reporting. Recognising the additional demands that this places on services in addition to the need to target hard-to-reach populations, the EVAWG documents reports that additional funding will be provided to support 'women from BME backgrounds, and innovative services for the most vulnerable with complex needs' (Home Office 2016: 11). There is, however, no mandate on commissioners or decision-makers on a localised basis to prioritise income for DVA services and resource-based challenges (such as competition for funding, piecemeal and short-term funding arrangements) persist (Rogers 2016). This is especially the case for agencies seeking to support hard-to-reach populations. For example, services for BME women, despite being described as 'lifelines', are often patchy and lack sustainability (Manjoo 2015).

The EVAWG strategy states that there is a Government commitment to strengthening the role of health services, noting that victim-survivors have indicated that healthcare workers are the professionals that they would be more likely to speak to about their experiences (Department of Health 2005; SafeLives n.d.). In 2014, the National Institute for Health and Care Excellence (NICE) published guidance to help health and social care commissioners and frontline practitioners whose work may bring them into contact with people who experience (or perpetrate) DVA. The aim of the guidance was to help identify, prevent and reduce domestic violence and abuse. The NICE guidance does acknowledge marginalised groups as people who experience abuse as there are brief sections on 'partner abuse among young people',

'abuse of older people' and 'honour'-based violence and forced marriage' (NICE 2014: 29–31). These are only scantily referenced, however, and the document identifies 'gaps in the evidence' pertaining to 'honour'-based violence, forced marriage, elder abuse, LGBT people and intimate partner violence among adolescents.

8.3 Lesbian, Gay, Bisexual, Trans and Queer Communities

As indicated in the Home Office's (2018) definition of DVA, and acknowledged by the World Health Organization (2017), DVA can be found in people's relationships irrespective of their gender and/or sexuality. As such, there is a sizeable body of global literature which explores the nature of DVA for lesbian, gay, bisexual, trans and queer (LGBTQ) communities. In terms of UK prevalence, using aggregated national survey data conducted between 2008 and 2011, Stonewall (Bachmann and Gooch 2018) claimed that one in four lesbian and bisexual women have experienced DVA in a relationship and almost half (49%) of all gay and bisexual men have experienced at least one incident of DVA from a family member or partner since the age of 16. There is limited research on how many trans or queer people experience DVA and existing studies have been conducted with small sample sizes. Nonetheless, the statistics available demonstrate that abuse experiences are common. For example, a small-scale study conducted in Scotland indicated that 80% of trans people have experienced some form of emotional, sexual, or physical abuse from a partner or ex-partner (Roch et al. 2010). In contrast, Rogers (2013, 2017) found that participants in her study were more likely to have experienced family violence than intimate partner abuse.

Whilst heterosexual and LGBTQ people might experience similar patterns of DVA, there are unique aspects of LGBTQ domestic violence and abuse. This includes:

- Threats of outing through disclosure of sexual orientation and gender identity to family, friends or work colleagues
- Threats of outing through disclosure of sexual orientation and gender identity to officials (for example, social workers for people with children)
- Undermining someone's sense of gender or sexual identity and exploiting a person's internalised negative self-beliefs
- Limiting or controlling access to spaces and networks that are helpful when coming to terms with gender and sexual identity and when coming out
- Controlling someone by convincing them that no-one would believe the abuse is real (exploiting heterosexist or heteronormative myths based on the 'public story')
- Manipulating victim-survivors into believing that abuse is a 'normal' part of same-sex relationships or pressuring victim-survivors into submission by minimalising abuse in the name of protecting the image of the LGBTQ community.

In addition, there are some trans-specific abuses which include withholding medication, preventing treatment or hiding gender signifiers (clothing, accessories, wigs) that are needed to express victim's gender identity or coercing someone into not pursuing medical treatment or gender reassignment. Identity abuse can occur when an

abuser refuses to use somebody's preferred name, the correct pronouns or threatens to out a person by disclosing someone's trans history. An abuser might use derogatory names and use 'body shaming' tactics (being derisory or ridiculing a person's body image) to manipulate and control. It is likely that these behaviours are not uncommon as a small-scale survey ($n = 71$) found that almost half of respondents (46%) reported DVA that was transphobic in nature (Scottish Transgender Alliance 2008).

Box 8.1 Case Study: Sam

Sam, aged 36 years old, had identified as a trans male for 2 years and he had recently started to take hormones. Sam lived with his partner, Brian. They had been together for 14 years when Sam disclosed his trans identity. Sam and Brian had two children: Beccy (aged 10) and Britney (aged 8). After the children had started school Sam had found work in the local gym as a receptionist. Brian was home alone most days, unable to work having endured a back injury in his former job as an electrician. When they met Sam was 18 years old and Brian was 33. Sam said:

> Brian is older than me and I have always looked up to him. I didn't have many friends at school, and I grew up in care and so never felt that I had much family. With Brian, I got a, you know, the sense of being in a family and that someone loved me. I'd never felt that I belonged to a family or to someone.

When Sam first disclosed that he was trans, Brian's response was to accuse Sam of having an affair with a colleague from the gym. Sam described how she'd always thought that Brian was open-minded and their best friends, Simon and Jonny, were in a same-sex relationship. Sam described Brian's behaviour after he had come out:

> In the few months after I told Brian, he kept telling me to get to the doctors and that I obviously had something wrong with my head. One night we were sat watching the telly and it was about trans people. Brian got more and more angry. He grabbed my shirt and, right in my face, shouted 'you'll never do it. You're not a man. I'm a real man. You'll always be a woman.' He told me to stop this rubbish, or get out. He got up, didn't even look at me, and went upstairs. It came from nowhere. I was utterly shocked. So shocked, I couldn't speak.

Nothing further happened for a few months other than a few mean comments from Brian every now and then when he had too much to drink. In the last 6 months, however, Sam had experienced lots of emotional abuse. Sam felt that Brian was playing mind games as his clothes kept disappearing and Brian would come home with presents that Sam did not particularly like or that reflected his former female identity (such as a cup with 'best mom', or clothing/accessories that were feminine in style). In the past couple of months Brian had become sexually demanding. He was also becoming more and more controlling and resentful if Sam went out without him. As a result, he rarely left the house without Brian other than to take/collect the girls to school and when going to work.

Time to Reflect

You are a healthcare professional who met Sam at a clinic for a condition unrelated to his trans status and he disclosed abuse to you. What do you think would be an 'enabler' in terms of supporting Sam to access help to leave this abusive relationship?

Any combination of abuse dynamics and behaviours identified earlier can prevent someone from speaking out. Indeed, the barriers to help-seeking behaviour for people who belong to LGBTQ communities are multiple and for those people who have previously experienced or expect homo/bi/transphobic responses from support services and/or the criminal justice system, this can be a significant barrier to speaking out. SafeLives (2018) recently reported that just 2.5% of all victim-survivors accessing DVA services in England and Wales identify as LGBTQ. The reasons for this are complex and multiple but studies of DVA in LGBTQ communities have indicated that abuse is not always recognised as such, but considered to be 'just something that happened' or 'wrong but not a crime' (Roch et al. 2010: 5). This may be the power of the 'public story' in action.

Research internationally indicates high levels of LGBTQ DVA with a higher risk of DVA for LGBTQ individuals compared to their heterosexual peers (Langenderfer-Magruder et al. 2016). In the US, a large-scale survey undertaken each year found that the rate of reporting for DVA rose by almost 6% from 2032 reports in 2016 to 2144 reports in 2017 (NCAVP 2017). The survey also reported that the number of domestic homicides in 2017 was slightly higher to those recorded in 2016. Of the 16 domestic homicides, nine victims (56%) were men, five (31%) were women and one victim (6%) was a trans man (NCAVP 2017). In Australia, it is reported that LGBTQ individuals experience DVA at similar rates as for heterosexual people (Campo and Tayton 2015). Yet, reflecting the earlier discussion, in Australia there has been an invisibility of LGBTQ relationships in policy and practice responses and a lack of acknowledgement that intimate partner violence exists in these communities (Campo and Tayton 2015).

8.4 Men's Experiences of DVA

The majority of DVA research considers women's victimhood and the debate about whether violence perpetrated against women and men has the same meaning and impact is unrelenting (Morgan and Wells 2016). This debate is contentious as there are writers who argue fiercely that the two are not comparable as women's experiences are rooted to the enduring dynamics and outcomes of patriarchy and gender inequality; both permeate societies and affect women in wide-ranging aspects of personal life (Stark 2007; Corbally 2015). As such, gender inequality is structural and it is associated with men's desire for power and control; key elements in women's experiences of DVA. There is no doubt that men's use of DVA against women is a serious and damaging problem experienced by women across the globe (WHO 2017) but there is also a growing body of literature which details men's victimisation (Drijber et al. 2013; Corbally 2015; Morgan and Wells 2016). Whilst

acknowledging these debates, and that DVA occurs for men in same-sex relationships, the focus here is on heterosexual men as victim-survivors when women are the perpetrators of abuse.

In terms of how men experience DVA, the existing evidence highlights that the abuse of men takes the same forms as for women in that it can be physical, sexual, psychological, financial and as coercive control. Abuse can be perpetrated by current or former partners. A study of 372 male victim-survivors in the Netherlands found that men reported that more than half (54%) of female perpetrators used an object during physical attacks (Drijber et al. 2013), a finding reported in other studies (Strauss and Gelles 1986). It was not, however, clear whether violence was one-way or bidirectional with violence alternating between partners. In his typology of DVA, Johnson (2008) terms this form of bidirectional abuse as situational couple violence. This occurs when conflict turns to aggression and then violence. Johnson argues that this form of DVA has gender symmetry in that both men and women will be perpetrators at similar rates.

There are studies which show significant impacts for men such as severe injuries (Nowinski and Bowen 2012) and behaviours which reflect intimate terrorism (Hines and Douglas 2010), another form of abuse named by Johnson (As discussed in Chap. 3). Intimate terrorism most likely represents a small proportion of all DVA but predominates among the cases of women that come to the attention of DVA services, the criminal justice system and other public agencies. Whilst men do experience intimate terrorism (Hines and Douglas 2010), the data are clear and illustrate that the primary perpetrators in heterosexual couples are men (Johnson 2008).

The work of Johnson and others, in this respect, bolsters the 'public story' (Donovan and Hester 2014) and this in turn can operate to marginalise men's victimhood in discussions of DVA. This can serve to restrict men's help-seeking for many reasons. On an individual level, reasons such as shame, embarrassment, the fear of ridicule or not being believed serve as significant barriers to seeking help (Barber 2008; Morgan and Wells 2016). Drijber et al.'s (2013) study in the Netherlands found that men were reluctant to report their abuse as they felt that services would not support them and that even if they attempted to report their experiences to the police that no action would be taken. Furthermore, Corbally (2015) observes that secondary victimisation through the responses of structures such as school, the police and court system is common for male victims.

8.5 Women with Learning Disabilities

Whilst there is a vast body of evidence illustrating the scale and nature of DVA in the general population, there is a much smaller body of research detailing the DVA of women with physical and sensory impairments (Thiara et al. 2011).

Moreover, evidence and scholarship highlighting DVA in the lives of women with learning disabilities are strikingly absent from policy and practice (McCarthy 2017a). This invisibility is illustrated in the annual census figures from Women's Aid Federation England (WAFE) as their annual census report for 2017–2018 found that only 2.6% of 18,895 service users, who were supported by 49 DVA services in England, identified as having a learning disability (Women's Aid 2019). What the existing evidence does show is that, similar to women with physical and sensory disabilities, women with learning disabilities are reportedly more susceptible to abusive relationships, but, as indicated by the Women's Aid census, have less access to DVA support and services (Hughes et al. 2012). In addition, women with learning disabilities are at a higher risk of more frequent and prolonged DVA than non-disabled women and disabled men (Brownridge et al. 2008; McCarthy et al. 2015). Women with learning disabilities are more likely to experience DVA as they do not receive adequate sex education, often lack the knowledge of what is appropriate within a relationship (McCarthy 2017b) and may be perceived as easy to manipulate and exploit. In addition, those with communication impairments are less able to report abusive behaviour to the appropriate agencies (Martin et al. 2006).

The types of DVA experienced by women with learning disabilities are similar to non-disabled women in that abuse can be physical, sexual, psychological and financial. In addition, in McCarthy et al.'s (2015) study, women with learning disabilities described how their abusers used their impairment to belittle and exploit, and coercive control was common. In relation to knowledge about abuse behaviours such as these, there are various sources of information created by, with and for people with learning disabilities which detail the nature and impact of abuse in general, but there is a dearth of practice guidance and appropriate tools for those working in health and social care in this regard. Additionally, research by Olsen et al. (2017) suggests that professionals lack the knowledge and confidence to assess and support people with learning disabilities who have experienced DVA. This was also the case for healthcare professionals as in McCarthy et al.'s study (2015), little or no action was taken unless women explicitly asked for help.

There are various barriers to accessing appropriate support for women with learning disabilities. Access to information is often lacking with information not available in easy-to-read formats. In McCarthy et al.'s (2015) study of 15 women with learning disabilities, 11 were unfamiliar with the word 'refuge' or did not know what help it could provide. Risk assessment tools, such as the DASH (domestic abuse, stalking and 'honour'-based violence) risk checklist are not appropriate for women with learning disabilities. The DASH tool is a generic risk identification checklist, but does not address the specificity of the person being assessed in terms of learning disability and would not, therefore, account for this as having any relevance in terms of presenting the situation; for example, in representing a risk factor.

8.6 Black and Ethnic Minority Communities

Domestic violence and abuse affects people from all communities and there is no evidence to suggest that women from black or minority ethnic (BME) or cultural minority groups are at any more at risk than others, but the form of abuse may vary. In some communities, for example, DVA might be perpetrated by extended family or community members. It might involve 'honour'-based abuse, child marriage, forced marriage or female genital mutilation. It is difficult to gain an accurate picture of the scale of DVA as many crimes of these types are hidden and go unreported (not unlike the other hard-to-reach communities discussed in this chapter). However, statistics collated by Women's Aid Federation England (WAFE) give some illustration. For example, the 2017–8 WAFE Annual Survey highlighted that of the total number of women accessing community-based services, were 'White British', the next two biggest categories were 'Asian/Asian British Pakistani' at 4.8% and 'Black/African/Caribbean/Black British African'' at 4.2% (with 23.6% in total representing BME women) (Women's Aid 2019).

Like people who identify as LGBT or Q, people from BME communities are very likely to experience additional barriers to help-seeking meaning that they do not always get the help that they need. Racism can compound experiences or be used to execute control and manipulate using fear of a racist response to prevent help-seeking behaviour. This fear is inflated if a person does not have a secure immigration status in this country (for example, if they are seeking asylum). There are additional challenges for women who do not have a secure immigration status as they are therefore unlikely to be able to access the same levels of support if they do not have access to public funding (Anitha 2011; Dudley 2017). If the abuser is from a BME background, the victim-survivor might not want to speak out in order to protect them from institutional racism, particularly if this has underpinned a prior experience. The fear of rejection from family or communities can be strong and act as a barrier to help-seeking.

The pressure that forced marriage brings can mean that there are worries about blame and damaging the family honour. This 'honour'-based ideology is associated with many ethnic groups, including communities from the Arab countries, Asian and African sub-continents as well as Gypsy, Roma and Travelling communities; see the case study of Bridget in Box 8.2. Various cultural and religious beliefs and norms based on patriarchal notions can be deeply embedded in such communities. 'Honour'-based violence and forced marriage pose problems in terms of identification and belonging, and these have become potent issues in debates on multiculturalism, citizenship, community cohesion and identity (Gill 2013). Forced marriage, in particular, is complex as it is less well understood and often contested but, importantly, it brings attention to whether consent to marriage is 'free', 'full' and 'informed' and this way it illuminates forms of forced marriage such as marriage as slavery, child marriage, marriage of convenience, marriage to acquire nationality and undesirable marriage (United Nations 2012).

Time to Reflect

What are the barriers to leaving for Bridget? What would help Bridget to leave Michael? How could a healthcare professional facilitate support for Bridget?

Box 8.2 Case Study: Bridget

Bridget is 32 years old and from an Irish Travelling Community. She married Michael when she was 16 years old and they have six children aged between 6 months and 16 years old. Michael holds strict and rigid expectations which are directed towards Bridget and the children. The running of the household reflects Michael's traditional views which are underpinned by patriarchal notions about gender norms, family practices and the division of labour. These views are widely held within their community too. Bridget is a devout Catholic and takes the children to church on a regular basis. Bridget has experienced abuse (physical, sexual, financial and emotional) from Michael starting on the day after they were married. In the last 2 years, Michael has become more demanding sexually and has raped Bridget on several occasions. Bridget knows that Michael's upbringing had been harsh; he had experienced cold and cruel parenting from his father and his mother had died in childbirth when Michael was just a boy. Bridget feels sorry for Michael as he has no other family nor anyone else to show him love or care.

Bridget has one sister, Mary, but, at times, Bridget struggles to maintain contact as Michael does not like her being out of the house. In the last year Bridget has managed to maintain contact with Mary every month when Mary visits. Bridget speaks to other women in her community, but is not close to anyone (and certainly has not discussed Michael's behaviour, or their marriage with the other women). Bridget has attempted to leave Michael twice before, but returned due to a strong sense of duty; she takes her wedding vows seriously. Bridget was also worried that she and her children would be expelled from their community and that they would be left without a place to call home and without a community to belong to. She also returned as Michael had promised to change (but this lasted for a day or two before signs of abusive behaviour began to creep back into day-to-day life).

8.7 Intersectionality

It is worth drawing attention to the fact that most people do not experience the world from one social location or because of one characteristic, but rather different aspects of their identity and background impacts on life experience. Intersectionality is a concept which has been used to analyse how people's different social positions overlap (Crenshaw 1989) or how social divisions are connected (Anthias 2008). Intersectionality frameworks were developed by Black feminist scholarship; a body of work originating in the 1970s. This work drew attention to persisting inequalities and the marginalisation of Black women initially through highlighting the ways in which white feminists failed to understand and theorise the multiplicity and complexity of identity (Richardson and Monro 2012). Intersectional analysis has been used to explore DVA at the junctures of race, class and gender (Sokoloff and Dupont 2005).

Traditionally, intersectionality frameworks have been employed to explore social divisions based on the interlinking of these (race, class and gender) but this limited usage has been critiqued along with the tendency to apply intersectionality in a rigid, mechanistic way (Anthias 2008; Ahmed 2015) or opaquely (Hines 2011). It is more useful to think of axes of difference (Yuval-Davis 2006), a matrix of domination (Hill Collins 2000), or of identity and its relation to a dynamic process of positionality (Ahmed 2015; Rogers and Ahmed 2017). Notwithstanding, intersectionality frameworks are helpful in reminding us to consider that narratives of violence and abuse are often underpinned by multiple, not singular, aspects of a person's identity, background and lived experience.

8.8 Health and Well-Being Impacts

There are many health and well-being impacts that are crosscutting in terms of outcomes for people who are affected by DVA. For example, there are health, mental health, economic, cultural and social impacts and within each of these categories, there are many different consequences of abuse and maltreatment. Physical injury and trauma are not uncommon for survivors of DVA. For people considered to be from hard-to-reach communities, there can be additional impacts: for example, for BME women, their abuser might limit or control their access to medical appointments or medication impacting on their health primarily. The fear of retribution from the community can also cause considerable stress and anxiety. For trans people, their abusers might limit or hide the things they need to maintain their gender transitioning (hiding or destroying hormone medication for example) which can be psychologically distressing.

Time to Reflect
Can you think of other specific health and well-being impacts of DVA that might affect people from the hard-to-reach communities included in this chapter?

8.9 Best Practice with Hard-to-Reach Groups

Many things can inform best practice when working with victim-survivors of DVA (such as conceptual and practice-focused frameworks as well as specific models and techniques). Best practice can be reified in something as simple as person-centred communication which asks questions about the micro-level (everyday) factors which affect an individual: for example, the more practical issues such as financial arrangements or the responsibility of having a pet, for instance. This can include the recognition of the complexity of emotions (such as love, duty, shame, self-blame and guilt). It is important to consider a person's informal and formal social networks in terms of their extended family, community membership or relationships with employers, colleagues or agencies already involved with the family. Best practice

with hard-to-reach groups, however, should also acknowledge macro-level factors such as institutional racism and structural inequalities. As the dynamics of abuse are inevitably entwined with power and control, it is imperative that our practice is mindful of this, and of the ways in which our engagement and intervention should seek to not reinforce the experiences of marginalisation and disempowerment.

Frameworks for practice, such as cultural competence and cultural humility, exist to support best practice with hard-to-reach groups. Effective engagement can rely on cultural competence which means that practitioners consider the social characteristics and backgrounds of victim-survivors (for example, gender, ethnicity, language, (dis) ability and other aspects of social location) (Birkenmaier et al. 2014). Before you can do this, you need to practice cultural humility which is the readiness to suspend what you know, or what you think you know, about a person using stereotypes and typecasting which are based on their culture, appearance or characteristics. Rather, what you learn about a person and their culture, background or identity evolves from what they express as being an important part of their sense of self and experiences of everyday life. There is another useful model that can underpin best practice with hard-to-reach groups and this is termed structural competence (Willging et al. 2019). A structural competency approach emerged in healthcare as a means of advancing the cultural competence model (which has been criticised for operating at a micro-level, recognising individual bias and prejudice only) to one which also embeds an acknowledgement of vulnerability and unequal outcomes as resulting from structural forces (which are much harder to break down) (Willging et al. 2019).

8.10 Summary

This chapter explored the global phenomenon of DVA. It has, however, departed from the 'public story' to discuss the issue from the perspective of different hard-to-reach groups including: LGBTQ populations; male victims; women with learning disabilities; and BME communities. Early in this chapter, it was argued that such groups have been hidden in much of the research, policy and practice on DVA, but that for each group there is a growing body of evidence to suggest that DVA is experienced at alarming rates. The chapter explored some of the barriers for hard-to-reach groups and provided case studies and reflective questions to help the reader to consider how healthcare practitioners can facilitate access to support, noting how it is reported that victim-survivors frequently state that they would rather disclose abuse experiences of healthcare practitioners than other professionals involved in their lives. This means that healthcare professionals are often best placed to help break down the barriers that hard-to-reach groups face in the context of DVA.

Summary Points

- As a healthcare professional you should be able to identify the additional barriers to recognising and naming their experiences as abuse for victim-survivors from hard-to-reach groups

- An appreciation of the additional barriers that prevent help-seeking and make it difficult to access appropriate support for victim-survivors from hard-to-reach groups
- Good practice in supporting victim-survivors from hard-to-reach groups includes a structural competency approach in order to consider individual experiences in the context of structural, systemic and institutional equalities and oppressions

8.11 Web Resources

- Barnados—Real Love Rocks. The online space all about raising awareness around child sexual exploitation and what a healthy and safe relationship is. https://www.barnardosrealloverocks.org.uk/
- Mankind is a confidential helpline for men escaping domestic violence. Website: www.mankind.org.uk. Telephone: 01823 334244.
- Galop's National LGBT Domestic Abuse Helpline is run by and for LGBT people and offers practical and emotional support to LGBT people experiencing domestic abuse. Website: www.galop.org.uk. Telephone: 0800 999 5428.
- The Forced Marriage Unit offers protection, advice and support to victims of forced marriage as well as information and practice guidelines for professionals. Website: https://www.gov.uk/guidance/forcedmarriage. Telephone: +44 (0) 207 008 0151. Email: fmu@fco.gov.uk and email for outreach work: fmuoutreach@fco.gov

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