Ending domestic abuse

Routes to Safety: An intersectional perspective

Technical Report

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Contents

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Introduction

The following project was undertaken by SafeLives to examine the impact of intersectionality on the pathways to safety for victim/survivors of domestic abuse. Funded by the Nuffield Foundation, the project was conducted over a 12-month period.

> *Intersectionality is not primarily about identity but about how structures make certain identities the consequence of and the vehicle for vulnerability. Intersectionality is an analytic sensibility, a way of thinking about identity and its relationship to power. It's about understanding and addressing how interlocking systems of power – such as race, gender, class, sexuality, and ability – create layers of disadvantage that are compounded for those who embody multiple marginalized identities.* (Crenshaw, 2015)

According to the Office for National Statistics (ONS, 2024), approximately one in five people aged 16 years and over have experienced domestic abuse since the age of 16, with 6.6% of women and 3.0% of men reporting that they had experienced domestic abuse in the last year. These figures demonstrate the widespread nature of domestic abuse; however, no two individuals experience domestic abuse in the same way. Experiences of domestic abuse are shaped by a range of personal and intersecting identities, such as ethnicity, gender, sexuality, disability status, and age.

The latest quarterly MARAC (Multi Agency Risk Assessment Conference) Data (April 2024 – March 2025) identifies the number of high-risk cases discussed at MARAC within the year. This identifies 128,434 cases discussed including 155,875 children within the households in the last year. This represents 48 cases per 10,000 of the adult female population. Nearly two thirds (63.5%) of these cases are referred by the police. Demographic data is captured on the victim/survivors which shows that cases where the victim/survivor is Black, Asian or racially minoritised (16.8%) is below the population and cases where the victim/survivor is identified as LGBT+ (1.6%) or as having a disability (10.6%) are below SafeLives recommendations. The proportion of cases where the victim/survivor is male (6.5%) is within SafeLives' recommendations. Victim/survivor demographic information is not representative of the national population and is below the SafeLives recommendation.

Existing research has shown that the further a victim/survivor is from a hypothetical 'norm', the more difficult it becomes for them to access support services (SafeLives, 2017a, 2018; Women's Aid, 2024). Studies have also demonstrated that victim/survivors' intersecting identities and needs are often poorly identified by practitioners (SafeLives, 2017a, 2018; Thiara & Roy, 2020), and that cultural misunderstandings among service providers present significant barriers to victim/survivors confidently seeking help (SafeLives, 2017b; Women's Aid, 2022). These barriers can result in victim/survivors choosing not to seek help due to not knowing where to turn, prior negative experiences with support services, or because their specific needs were previously unmet. When services fail to respond appropriately to the complexity of victim/survivors' identities, it can reinforce feelings of mistrust, exclusion, and helplessness. Despite growing recognition of the importance of intersectionality within domestic abuse research, there remains a lack of detailed exploration into how intersecting identities influence help-seeking behaviours, access to safety, and clients' needs on entry to the service. This research aims to further the understanding in this area using both quantitative and qualitative data.

Use of language

Safelives defines 'victims' of domestic abuse as people who currently live in danger and 'survivor' to describe the person from the moment they start to receive support/move on from the abuse. For this report, we use 'victim/survivor' to describe anyone with an experience of domestic abuse.

Research Questions

Domestic abuse

Domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between a victim and their perpetrator regardless of gender or sexuality. This can encompass – but is not limited to – psychological, physical, sexual, financial, and emotional abuse. Domestic abuse can be perpetrated by a partner or ex-partner, family member, or carer.

This study addressed gaps in knowledge and explored the relationship between referral pathways, victim/survivors' intersecting identities, and resulting safety outcomes, to inform the development and implementation of policy and practice related to victim/survivor welfare.

How is a victim/survivor's journey to safety influenced by referral pathways and intersecting identity?
1. How do referral pathways and the length of abuse vary across intersecting identities?
2. How does risk profile differ according to intersecting identities?
3. How do victim/survivors' identified needs differ based on intersecting identities?
4. How do safety outcomes differ by intersecting victim/survivor identity?

Method

A mixed methods approach was taken to investigate the research questions. There were three stages of the study 1) rapid realist literature review to identify existing research relevant to the project and to highlight gaps in the evidence base; 2) quantitative data analysis of SafeLives Insights data; 3) qualitative data was collected and analysed through semi-structured interviews with victim/survivors and professionals.

Rapid Literature Review

The project began with a rapid systematic literature review to synthesise existing domestic abuse literature exploring experiences and risk through an intersectional lens. In the first phase, the following overarching criteria were used to search for potentially relevant literature:

- UK literature
- 2014 onwards
- Papers in English
- Focus on IPV / domestic violence / domestic abuse
- Qualitative and mixed methods research
- Academic literature

The titles and abstracts of the resulting 1,785 articles were then further screened using Rayyan software to exclude any that did not meet the inclusion criteria, and any duplicates; the remain articles were categorised into high, medium, and low relevance with the following criteria:

- High relevance: relevant to at least one of the research questions, and includes stratification by intersectional identities which align with the definition of protected or additional characteristics.
- Medium relevance: includes stratification by intersectional identities which align with the definition of protected or additional characteristics but does not specifically identify information relating to the research questions.
- Low relevance: does not mention intersectional identities that align with the definition of protected or additional characteristics and does not mention topics relating to the research questions.

There were 47 high and medium relevance articles read in full by members of the research team.

Quantitative Data Analysis

SafeLives' Insights

SafeLives' Insights data contains anonymised case level data collected by frontline professionals from 29 services when a victim/survivor enters the service and when they exit the service. It supports services to better understand the impact of their work and the people they support. Data has been included for 30,814 victim/survivors between January 2016 and October 2024. This date range has been included with advice from the advisory groups to allow for a larger number of cases and to track any changes over time.

Data included demographic characteristics (gender, age, ethnicity, sexuality, and disability status), date case opened and closed, referral route, risk profile at intake and exit, needs on intake, level of abuse on intake and exit and client reported outcomes at exit.

More information is available on the SafeLives website

The quantitative analysis had four main components:

1) **Descriptive statistics** were initially conducted to summarise the characteristics of the sample and to explore patterns in the outcome and demographic variables.

2) **Multilevel modelling** was employed to account for the hierarchical structure of the data, with individual victim/survivors at Level 1 nested within service providers at Level 2. This enabled assessment of individual and service-level variation in the outcome variables and facilitated identification of specific victim/survivor identities that significantly influenced outcomes.

3) **Interaction effects** were included in the model to explore the influence of victim/survivors intersecting identities. The interaction between the following key demographic variables were included (ethnicity × sexuality, ethnicity × disability, age × ethnicity, and age × sexuality). These interactions were analysed exclusively among female participants, given that the sample was predominantly female.

4) **Intersectional identity analysis** was used to build on the multilevel model and further explore the interaction of an individual's multiple identities. Alongside the service provider nesting, this model included random effects for identity strata, defined as unique combinations of five demographic variables: age, gender, ethnicity, sexuality, and disability. This enabled the estimation of residual group-level variation attributable to intersectional identity profiles, while controlling for all fixed effects.

Qualitative Data

Marginalised identities

Marginalised identities are social identities or characteristics of individuals or groups that are systematically disadvantaged, excluded, or discriminated against within society. Examples include, but are not limited to, individual from minority ethnic groups, LGBTQ+ individuals, people with disabilities.

Semi-structured interviews took place with victim/survivors of domestic abuse who have intersectional or multiple marginalised identities, and professionals who work with these victim/survivors. The recruitment and interview schedules were co-created with pioneers with input from the research advisory group. The project adhered to our established research processes, and our internal ethics board reviewed and approved the approach.

Participant recruitment

A recruitment poster for professionals and victim/survivors directed individuals to information about the project and links to expression of interest (EOI) forms. For victim/survivors' this included the option to be added into a prize draw. This was shared through the SafeLives network including the newsletter; partner organisations; policy team; sector calls; Insights and leading lights services; and additional mailing lists and shared through members of the advisory groups. Expression of interest forms were

available in an accessible format, with an introduction in six languages (English, Gujarati, Urdu, Punjabi, Polish, and Arabic) stating documents can be provided in different formats. The recruitment was open for 18 weeks between 18 March and 23 July 2025.

Demographics for the nine victim/survivors completing the expression of interest is as follows:

- Seven self-identified as female and one as male
- Four respondents identified as White, two as belonging to another ethnic group, one as Mixed or Multiple ethnic backgrounds, and one as Black, Black British, Caribbean, or African.
- Five respondents reported having a long-term physical or mental health condition.
- Additional marginalised identities were disclosed during the interviews such as neurodiversity and sexual orientation.

Professionals' organisations including domestic abuse services, statutory services such as police and children's social care and health and voluntary services. The professionals supported a range of individuals with specific identities or needs of respondents, four supported ethnically minoritised communities, two supported younger people, four provided gender-specific support, and two supported people with disabilities. Accessibility was asked about throughout the project.

Schedule Design

Semi-structured interview schedules were developed for consistency, alignment with the research questions and to incorporate relevant prompts. Each interview established a safe and supportive space, obtaining informed consent, and then progressed to the interview questions. The victim/survivor interview schedule included 11 core questions, while the professional schedule contained 14 questions. Following the initial interviews with both victim/survivors and professionals, the interview schedules were reviewed with minimal amendments made based on feedback.

Interview Process

Detailed information about the project and written consent was shared / obtained before arranging each interview. Verbal consent was then sought / given to ensure ongoing informed participation. Victim/survivors who took part in the interviews received a £25 voucher of their choice as compensation. In recognition of the limited resources available to smaller 'by and for' organisations, and the value of their contributions, we also offered £125 compensation to the organisation for their participation. All the interviews were conducted virtually and were professionally transcribed.

Anonymity

Anonymity was a key consideration throughout the qualitative research process to ensure participants felt safe and protected when sharing their experiences. Personal identifiers were removed from all transcripts and assigned codes to maintain confidentiality. Any potentially identifying details were either omitted or altered during transcription and reporting.

Qualitative Data Analysis Methods

Data analysis of the interview transcripts was based on the concepts of thematic analysis (Clarke, Braun, & Hayfield, 2015). We primarily utilised deductive codes but allowed for some inductive coding. This approach enabled us, as researchers, to draw on insights from existing literature while remaining open to additional themes and perspectives within the data (Mihas and Odum, 2019). A quality assurance process was included to allow for consistency in coding and reduce the likelihood of researcher bias.

Limitations

This research used a mixed methods approach to address some of the limitations associated with the individual research methods and considered evidence from multiple sources. The integration of a rapid review, quantitative Insights data, and qualitative interviews provide both breadth and depth to the analysis. Despite the strengths of the study, several limitations should be acknowledged.

Limitations associated with the use of Insights data

- The Insights dataset is a large dataset which consisted of over 30,000 cases; however, as with any quantitative data the focus of the analysis is on 'what' rather than 'how' or 'why'. Quality assurance takes place with insights services to ensure consistency in interpretation of the questions and in competition of the questions to avoid missing data; however, there could be some differences which takes place between practitioners and services. Differences between services have been accounted for in the statistical models but there may be some differences between individual practitioners that have not been accounted for in the models.
- The ability to generalise the findings is restricted. Insights data include only victim/survivors who have accessed services that use Insights to record data. As a result, the findings are not representative of all victim/survivors accessing domestic abuse services across the UK, nor of those who do not access services.
- The dataset reflects information collected by professionals from 29 domestic abuse services that used Insights at some point between 2016 and 2024. The services are based across England and Wales, with no services based in Scotland (however, some services did hold cases from victim/survivors living in Scotland). Insights collects information on where victim/survivors live, and the data includes individuals from 189 local authorities. Not all the services captured data via Insights for the entire timeframe. The geographical coverage represented in the dataset may not reflect all domestic abuse services nationally.
- Some subgroups such as victim/survivors from Black/African/Caribbean/Black British backgrounds, mixed or multiple ethnic backgrounds, other minoritised ethnic groups, those who identify as male or in another way, those who identify as LGBT+, and those under 18 years old are represented by smaller samples, limiting the reliability of findings relating specifically to these groups. Full details of the demographic breakdown can be seen in the appendix. Where the numbers are very low the relating data has been removed from the tables.
- Although most of the questions within Insights have remained static, some tweaks to questions and categories have taken place between 2016 and 2024. Where possible the responses have then been matched with the new categories and remain unchanged where this was not possible.

Limitation associated with qualitative analysis

- The focus of the qualitative research is on gaining an in-depth subjective understanding of victim/survivors' experiences and reflections and as such may not be generalisable.
- Seven victim/survivors and six professionals participated in interviews, and all were recruited through opportunity sampling. Information was captured on the demographics of the victim/survivors; however, there are many possible unique marginalised intersectional identities, and it would be difficult to be representative of all combinations of identities. Future research could explore specific intersections of marginalised identities in greater depth to further illuminate the diverse experiences of victim/survivors.
- Most participants were female, and although a range of ages were interviewed, there were more limited perspectives from older and younger victim/survivors. Future research could address these limitations.
- To reduce interviewer bias semi-structured interview schedules including prompts were used which were co-designed with our pioneers and reviewed by our research advisory group. Braun and Clarke's approach to thematic analysis was used to create structure and allow a reflexive approach for the researchers to reflect on any biases. Pioneers and the research advisory group were engaged in reviewing the approach and findings.
- Despite using several different recruitment approaches the majority of victim/survivors interviewed had received some support from services. Future research could explore recruitment of victim/survivors who had not received support.
- A range of professionals from different organisations were interviewed; however, given additional time and resources further variety of organisations could be included in future research.

Limitation associated with the rapid review

- The rapid review included UK published qualitative articles with a focus on IPV from 2014. The purpose of limiting evidence to the UK was to recognise the importance of context in the rapid realist framework; however, there may be interesting articles that are outside of the UK that were not included. Due to time restriction and the focus of the rapid review there is limited grey literature included in the review, which means unpublished evidence is not included.

Findings

Rapid Literature Review

Five themes were identified in the literature alongside learning of differential consequences and referral pathways.

Differential visibility

The literature identified that that the visibility of victim/survivors to services that may be able to identify and respond to abuse is impacted by their identities and the intersections between them. Some identities were described as increasing victim/survivors' visibility to services. These were most likely to be transitional identities like pregnancy, where there is often more frequent engagement with healthcare services (Barnes et al, 2024). However, for some disabled mothers and those with learning difficulties, the fear of having children removed due to stigma around parenting as someone with a disability or learning difficulty, acted as a barrier to engagement with maternity healthcare services and therefore did not increase visibility in the same way (Bradbury-Jones et al, 2015).

The literature demonstrated how victim/survivors with marginalised identities often felt less visible within society, due to the devaluing and othering of minoritised groups. This was seen within Wydall et al's (2023) article about older lesbian, gay and bisexual victim/survivors' lived experiences, which described the lack of value felt by older, queer people, who experienced ostracisation from peers due to their sexuality, and within the queer community due to their age.

Several articles highlighted how identities can be differentially visible to the individual themselves. This was most often talked about in relation to disability and individuals being aware of their experiences, but not that they meet the definition of a disability or being aware but choosing not to identify with this label (Bradbury-Jones et al, 2015).

When it comes to the link between differential visibility and exposure to abuse decreased visibility may mean victim/survivors experience abuse for longer, due to not being seen by services who might be able to identify abuse and intervene with support. However, the literature also highlighted missed opportunities by services for identification and support, even in the case of pregnant victim/survivors who have more frequent contact with services (Barnes et al, 2024). The literature highlighted that whilst increased visibility to services acted as a protective factor for some victim/survivors, it would mean increased risk for others, for example victim/survivors with insecure visa status may risk deportation if they become more visible (Femi-Ajao, 2018). For these victim/survivors, visibility may be a protective factor for stopping abuse, and a significant safety risk around other parts of their identity (Femi-Ajao, 2018). In this way, the differential visibility of victim/survivors also means differential vulnerability.

Learnt Distrust of Services

The existence of systemic forms of inequality and oppression, such as institutional racism, mean that marginalised victim/survivors are more likely to have had previous negative interactions with services, whether these are their own direct experiences or those of others within their communities (Evans & Feder, 2014; Idriss, 2020). Learnt distrust can act as a barrier to accessing services and disclosing abuse, with a lack of trust in professionals and previous experiences of unhelpful disclosures preventing victim/survivors from engaging with services or making further disclosures (Evans & Feder, 2014; Dixton et al, 2022).

Specific barriers were highlighted to accessing the healthcare system. During the height of the COVID-19 pandemic, this was due to high patient demand (Alderson et al. 2022), and for those not native to the UK, an unfamiliarity with how the healthcare system operates here was a substantial barrier to accessing it, as were language barriers for those who spoke little or no English (Desai et al, 2024). These barriers to accessing services which regularly identify and refer victim/survivors to specialist domestic abuse support, particularly the healthcare system and the police, the latter of which was the main referrer to both outreach and IDVA services in recent Insights data (SafeLives, 2024), may mean marginalised victim/survivors experience abuse for longer before identification and intervention.

The literature makes clear that when disclosure does happen, marginalised victim/survivors require specialist support that is based on an understanding of the intersections of their experiences of abuse and experiences related to other marginalised identities. Barnes et al (2024) reflect on the experiences of Trans victim/survivors who often do not feel safe accessing mainstream domestic abuse services and

face the complexities of navigating ‘single sex’ spaces. Similarly, male victim/survivors were also found to encounter gender bias from services and are sometimes not believed about their experiences of abuse (Dixton et al, 2022). This tailored and safe support is most often found in the form of specialist ‘by and for’ services. However, these services often do not receive the same levels or consistency of funding as mainstream domestic abuse support and are not as readily available. This means some marginalised victim/survivors may be left with DA support that is not suitable, or with no support at all if they do not feel safe or comfortable engaging with mainstream services. Victim/survivors with insecure visa status or no recourse to public funds may not be deemed eligible for certain services or aspects of support, for example refuge (Voolma, 2018).

Increased Isolation

Discussion of victim/survivors’ experiences of domestic abuse within the literature demonstrated that elements present in an individual’s exposome – all their exposures up to the point of experiencing abuse, are often then present in their experience of abuse.

Within the literature there were many examples of individuals experiencing isolation due to factors linked to their identities and as a result of their identities themselves, including language barriers (Desai et al, 2024), insecure visa status meaning an inability to work (Alderson et al, 2022), cultural differences meaning lack of socialisation outside of the immediate community (Tsegay & Tecleberhan 2023), and isolation experienced by trans youth (Barnes et al, 2024) and older men (Bates & Carthy, 2020). During experiences of abuse, perpetrators would then exacerbate the isolation already being experienced, as a means of control (Bates & Carthy 2020; Mulvihill et al, 2023).

While isolation has been established as a common tactic used by perpetrators of domestic abuse,, the layered isolation experienced by marginalised victim/survivors may make them additionally vulnerable, and can become a long-lasting consequence of abuse whether the relationship continues or ends (Heron et al, 2022; Evans & Feder, 2014; Mulvihill et al, 2023; Femi-Ajao, 2018; Dixton et al, 2022).

For victim/survivors whose communities shame divorce due to religious or cultural beliefs, the literature highlighted ostracisation and further isolation as potential consequences of disclosure and leaving an abusive relationship (Mulvihill et al, 2023; Femi-Ajao, 2018). For these victim/survivors, isolation was part of their experience before abuse, a tactic used by their perpetrator, and a potential consequence of escaping the abusive relationship.

Experiences of Prejudice and Hate

The literature highlighted how the prejudice that marginalised people experience around their identities, shapes their experiences of abuse. Articles focused on queer and trans victim/survivors demonstrated that people whose sexualities and gender identities are othered by prevailing patriarchal and heteronormative attitudes in society often experience a minimising of their experiences in general (Todd, 2021). This minimising acts as a barrier to disclosure of abuse due to additional fears of not being believed or taken seriously, and leaves queer and trans victim/survivors additionally vulnerable due to harmful responses to disclosure and their experiences of abuse being minimised by friends and family and/or professionals upon disclosure (Lahti, 2023; Mulvihill et al, 2023; Todd, 2021).

Prevailing heteronormativity and prejudice towards queer and trans people, as well as societal ableism, has resulted in a lack of relevant, accessible and adequate RSE for victim/survivors who are not heterosexual, able-bodied and do not identify with binary genders (Barnes et a, 2024). This means a lack of relevant information and understanding of what a healthy relationship could and should look like, and what abuse might look like in these relationships. Within the literature reviewed, this led to experiences of abuse being normalised rather than recognised as abuse (Bradbury-Jones et al, 2015; Todd, 2021).

The literature discusses prejudice faced by male victim/survivors due to the gendered framing of domestic abuse (Dixton et al., 2022). As services are often designed with female victim/survivors in mind, there is a shortage of appropriate support for men. Male victim/survivors may experience gender bias when engaging with services, being disbelieved about their abuse, which can prevent them from receiving help and result in them remaining in abusive relationships longer (Dixton et al., 2022). Furthermore, literature reports that some female perpetrators threaten to claim victimhood themselves and allege abuse by the male partner, sometimes using the threat of removing children as a means of control if the abuse is disclosed (Dixton et al., 2022).

The literature highlighted how perpetrators use existing prejudice within society as part of their abuse of marginalised victim/survivors. This included threatening to reveal hidden identities such as the

victim/survivor being trans (Rogers, 2019), and other threats based on societal prejudices, such as a white perpetrator threatening to tell people their Muslim victim/survivor of colour was a terrorist (Butterby & Donovan, 2023), as well as drawing on other sources of authority in the victim's life to justify and normalise the abuse, for example using religious beliefs espoused by a religious authority figure to control (Idriss, 2020).

Normalisation

Discussion of different marginalized victim/survivors' experiences of abuse within the literature demonstrated that for many, experiences of oppression mean the normalisation of elements of the experience of domestic abuse before it takes place. As already discussed, those with insecure visa status within the literature referred to living in constant fear of identification and deportation (Femi-Ajao, 2018; Voolma, 2018), resulting in living in a state of fear being normalized. For other victim/survivors, being part of communities whose cultural and religious beliefs either advocated for, or were used to advocate for, patriarchy and the subjugation of women, in some cases framing abuse as justified and a part of normal married life (El Abani & Pourmehdi, 2021), meant the concepts of subjugation and abuse were normalised even before they were experienced directly.

Normalisation acts as a barrier to recognition of abuse as abuse, or as something wrong warranting support, which may lead to prolonged exposure to abuse (Tsegay & Tecleberhan, 2023). Support of marginalised victim/survivors may need to involve challenging these beliefs in a way which does not undermine a victim's religion or culture, which requires support from practitioners with a full understanding.

Differential consequences

While there was far less in the literature around differential consequences for victim/survivors with different identities, some articles reference specific short and long-term impacts on the victim/survivors themselves, as well as impacts relating to children.

Impacts on self:

- Increase in psychological, physical, and financial consequences, including the inability to afford legal representation and long-term debt (Alderson, 2022; Desia et al, 2024; McCarthy et al 2017).
- Loss of independence and continued isolation (Dixton et al, 2022; Mulvihill et al, 2023).
- Loss of sense of self (Dixton et al, 2022; Mulvihill et al, 2023).
- Loss of religious community through ostracization (Heron et al, 2022).
- Deportation and risk of harm or death upon return (Voolma, 2018).
- Passive coping – developing substance misuse issues (Heron et al, 2022).

Impacts on children/relating to children:

- Children and young people experiencing mental health issues, lower educational attainment, future experiences of IPV and ill health, manifesting violent behaviour, being bullied by peers (Alderson, 2022; Maggie A et al, 2014; Evans & Feder, 2014; McCarthy et al 2017).
- Miscarriage (Heron et al, 2022; McCarthy et al 2017).
- Pregnancy (Mulvihill et al, 2023; McCarthy et al 2017).
- More children to raise than may have been chosen – financial impacts of this among many other impacts (Mulvihill et al, 2023).

Referral pathways

The key message relating to referral pathways and access to support was that services need to be proactive in enquiry, referral and support. While healthcare providers were referenced as a significant referral source for marginalised victim/survivors, this was mainly through self-disclosure rather than enquiry (Evans & Feder, 2014) and as this review has already highlighted, the many barriers to disclosure for marginalised victim/survivors, especially to healthcare services, mean relying on self-disclosure may lead to prolonged exposure to abuse. In cases where services were proactive, this led to improved outcomes (Evans & Feder, 2014), for example police taking victim/survivors to refuge and GPs making referrals themselves.

Gaps

The rapid review identified some remaining gaps in knowledge and approach. Though the included articles discussed at least two identities and how these shaped experiences of abuse and of services, most discussed each identity separately and few explored the intersections.

As already highlighted, while the literature contained lots of learning related to the exposome and differential vulnerabilities, it often did not explore what this meant in terms of differential consequences, or the 'so what'. Where this was considered, it was more often focused on consequences for children, rather than adult victim/survivors.

These gaps suggest a need for an approach to exploring identity and domestic abuse which is 'whole person' and considers how the intersection of all a victim/survivor's identities shape their exposome, as well as how this then shapes their experiences of domestic abuse and services. They also suggest a need for further exploration of the 'so what'; how do these differential experiences of domestic abuse and services differentially impact victim/survivors in the short and long term?

Quantitative Data Analysis

Summary of Key Quantitative Findings by Research Question

How do referral pathways and length of abuse differ by intersecting identity?

- Referral pathways differ across identities. Fewer referrals are made by the police for victim/survivors who are Black/African/Caribbean/Black British, Asian/Asian British, and those with a disability.
- Asian/Asian British victim/survivors, Black/African/Caribbean/Black British victim/survivors, those from mixed/multiple ethnic groups, other ethnic groups, and individuals with a disability are more likely to be referred through helpline.
- Young people are more likely to be referred by children's social care.
- The victim/survivor's identity impacts the length of abuse experienced before receiving support from domestic abuse services. When the victim/survivor is disabled, from an ethnic minority, or over-50, the average length of abuse is increased. This increased length of abuse is compounded by intersectional identities, where disabled victim/survivors who are both older and from an ethnic minority experience abuse for the longest time before receiving support.
- On average white women experience domestic abuse for 70.7 months. This increases to 74.2 months for white disabled women. However, Asian / Asian British women experience domestic abuse for 89.8 months which increases to 105.6 months for Asian / Asian British disabled women.
- When we apply the intersectional lens through our analysis, we can see that intersectional identity has a compounding effect where the length of abuse is significantly different than would be expected from the individual identities on their own. This means that longer lengths of abuse are seen for the following identities:
    - White, heterosexual females aged 51 and older, with a disability and without a disability
    - Asian / Asian British, heterosexual females aged 51 and older, without a disability
    - Asian / Asian British, heterosexual females aged 36-50 with a disability

And shorter lengths of abuse for the following identities:

- White, heterosexual females aged 18 and under without a disability
- White, heterosexual males aged 51 and older, with a disability and without a disability
- Asian / Asian British, heterosexual females aged 19-35 without a disability

DASH (domestic abuse, stalking and 'honour' based abuse risk checklist)

The DASH is one component of a wider risk-care pathway, supporting professional judgement. DASH is a structured tool used across multi-agencies and is the most commonly used risk assessment tool in the UK (Armitage, 2024). It is consistently recorded at intake and exit by the services using insights to support safety planning. It is a numerical assessment of risk factors being faced by individuals experiencing domestic abuse and it is not a predictive tool for future risk.

How does risk profile differ by intersecting identity?

- One of the ways that risk is measured in Insights is through the number of ticks on the DASH at intake and at exit. We can see that a higher number of ticks on the DASH at intake were seen for disabled victim/survivors, LGBT+ victim/survivors, victim/survivor that identify as female or identify their gender in another way or aged 19-35. We can also see that the number of ticks appears to decrease with age, with victim/survivors aged 51 and over having a lower number of ticks at intake. A lower number of ticks were also seen for certain Black, Asian and racially minoritised communities (Asian / Asian British and Black, African, Caribbean, or Black British).

- When applying an intersectional analysis, we see that intersectional identity has a compounding effect where the number of ticks at intake is significantly different than would be expected from the individual identities on their own. Fewer ticks are seen than would be expected for white, heterosexual females aged 51 and older with a disability.

- The types and severity of abuse being experienced is different across different identities. Our analysis identified the following differences:
    - Physical abuse, sexual abuse, harassment and stalking and jealous and controlling behaviour decreases with age.
    - Higher levels of physical abuse were reported by white victim/survivors compared to Asian / Asian British and Black, African, Caribbean, or Black British victim/survivors. This is particularly relevant when considering the pattern of seeking support described in the interviews, where individuals seek support at the point of crisis which, typically when this became physical abuse.
    - Specific intersections of identity were also identified as experiencing different levels of physical abuse, particularly around sexuality and age. With some of the non-heterosexual younger age groups experienced lower levels of physical abuse compared to the heterosexual women in the same age group.
    - Asian / Asian British victim/survivors identified lower severity of physical abuse, harassment and stalking and jealous and controlling behaviour and higher severity of sexual abuse. However, for female victim/survivors aged 51+ and Asian / Asian British the severity of harassment and stalking is higher.
- There were differences in the change in risk profile from when a victim/survivor entered a service to when they exited the services with some identities having a greater reduction in risk and some a lower reduction in risk. Further research is needed to understand the differences considering risk at intake compared to exit.
- When we compared the intersection of identities, we can see that ethnicity and disability have a significant interaction. Specifically, the combination of being both Black, African, Caribbean, or Black British and having a disability is associated with a smaller reduction in risk from intake to exit where the average reduction on ticks was 1.8 compared to 2.6 for white victim/survivors who had a disability.

How do victim/survivors needs differ by intersecting identity?

- The average number of needs identified for each demographic at intake increases for Black, Asian and racially minoritised victim/survivors; disabled victim/survivors; female victim/survivors; and bisexual victim/survivors.
- The types of needs identified at intake and during domestic abuse response differ across identities:
    - LGBT+ victim/survivors were more likely to identify needs around alcohol, drug misuse, employment, education and training
    - Disabled victim/survivors were more likely to identify needs around alcohol, drug misuse, finance, benefits and debt
    - Black, Asian and racially minoritised victim/survivors were less likely to identify needs around alcohol. They were more likely to identify needs for employment, education and training, finance, benefits and debt and immigration
    - Victim/survivors aged 18 and under were most likely to have needs around employment, education, and training, and those aged 19-35 and 35-50 were also more likely to have this need than those aged 51+
    - Female victim/survivors and those that identify in another way were more likely to have housing needs than male victim/survivors

How do outcomes differ by intersecting identity?

- There are differences in outcomes by different identities following support:

- Individuals aged between 19-35 identify higher feelings of safety and higher improvements in quality of life after receiving support.
- There are lower perceptions on improvement for wellbeing and quality of life for disabled victim/survivors and this is more pronounced for disabled Black and Black British victim/survivors.
- Asian / Asian British victim/survivors identify higher perceptions of safety, wellbeing and quality of life after receiving support.

Summary of Key Quantitative Findings by identity

Gender

- Male victim/survivors tended to experience abuse for shorter durations, had lower risk levels at intake, and reported lower levels of sexual abuse, harassment, and stalking, as well as jealous and controlling behaviours compared to female victim/survivors. Across all outcome measures, males also reported lower levels overall.

Age

- Younger victim/survivors experienced abuse for shorter periods but presented with higher risk levels at intake. They also reported higher levels across all four types of abuse examined.
- In contrast, older victim/survivors (aged 51 and above) experienced abuse over longer periods but had lower risk levels at intake and reported lower incidences of sexual abuse, harassment and stalking, and jealous and controlling behaviours.

Ethnicity

- Victim/survivors from Black, Asian and racially minoritised communities were less likely to be referred through police channels and more likely to access support via helplines compared to White victim/survivors. They reported higher levels of sexual abuse at intake but lower levels of harassment and stalking, and jealous and controlling behaviours. At exit, they generally reported greater improvements in safety, wellbeing, and quality of life than their White counterparts.
- Asian/Asian British and Black/Black British victim/survivors experienced abuse for longer durations but entered services with lower risk levels and reported lower levels of physical abuse.

Sexual Orientation

- LGBT+ victim/survivors reported greater mental health needs than heterosexual victim/survivors. Although they experienced abuse for shorter periods before seeking help, they reported higher levels of jealous and controlling behaviour.

Disability

- Disabled victim/survivors experienced longer durations of abuse, entered with higher risk profiles, and were more likely to report certain types of abuse than non-disabled individuals. They also showed smaller reductions in risk levels at exit and reported less improvement across outcome measures.

Intersectionality

- The presence of a disability often compounded other identities, resulting in more negative outcomes. For instance,
  - Asian/Asian British disabled victim/survivors reported longer durations of abuse and higher levels of harassment and stalking than their non-disabled peers.
- Similarly, Black/Black British victim/survivors with a disability reported lower improvements in quality of life and feelings of safety than those without a disability.
  - Victim/survivors from ‘Other ethnic groups’ with a disability reported higher levels of harassment and stalking than those without a disability.
- The data revealed several notable interaction effects between age and ethnicity:
  - Among Asian / Asian British victim/survivors, those aged 18 and under experienced longer durations of abuse, whereas individuals aged 19–35 experienced abuse for shorter periods. However, for Asian / Asian British victim/survivors aged 51 and over, there were higher levels of harassment and stalking reported at intake.

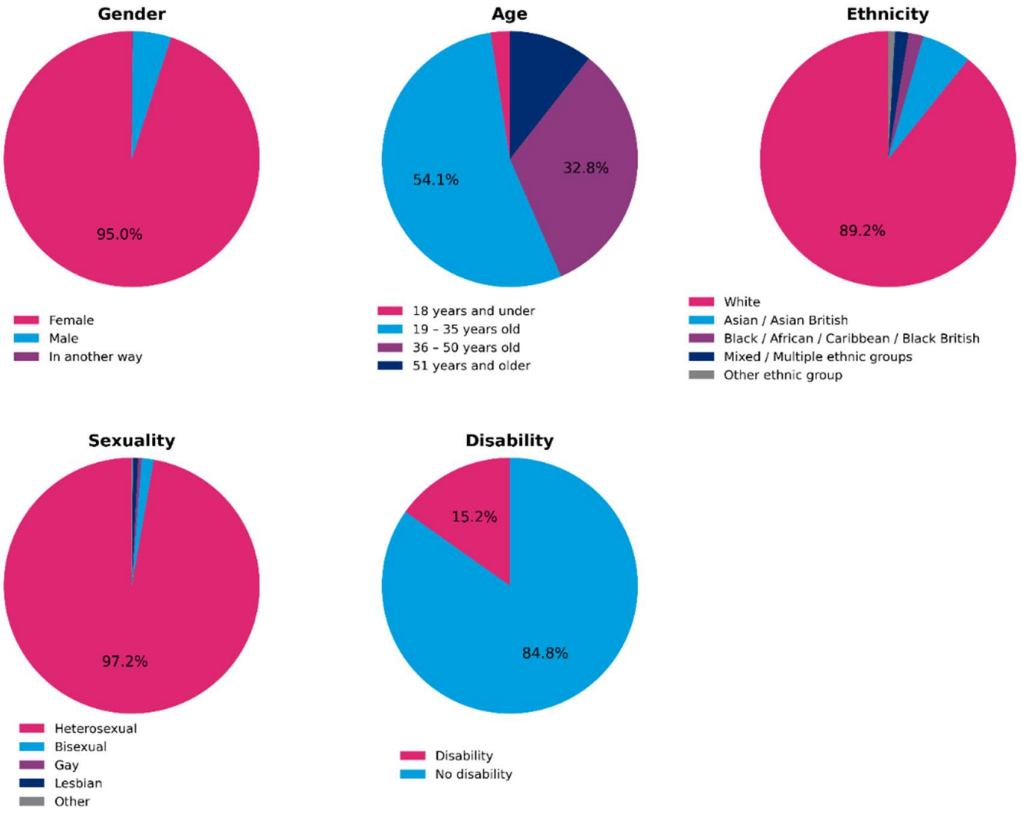
- For Black / Black British victim/survivors, those aged 19–35 reported higher levels of sexual abuse at intake, while those aged 51 and over experienced shorter durations of abuse.
- Victim/survivors from 'Other' ethnic groups also showed distinct patterns. Those under 18 reported lower improvements in wellbeing by the end of support, while those aged 51 and over reported higher levels of harassment and stalking at intake.

Descriptive Statistics

Descriptive statistics for all the independent variable included in the analyses are listed in Table 1. A total of 30,814 victim/survivors were included in the analysis.

Variable	N	% of Demographic
Gender		
Female	29278	95.0
Male	1494	4.8
In another way	42	0.1
Age		
18 years and under	747	2.4
19 – 35 years old	16682	54.1
36 – 50 years old	10122	32.8
51 years and older	3263	10.6
Ethnicity		
White	27487	89.2
Asian / Asian British	1944	6.3
Black / African / Caribbean / Black British	582	1.9
Mixed / Multiple ethnic groups	530	1.7
Other ethnic group	271	0.9
Sexuality		
Heterosexual	29964	97.2
Bisexual	463	1.5
Gay	138	0.4
Lesbian	209	0.7
Other	40	0.1
Disability		
Disability	4684	15.2
No disability	26130	84.8

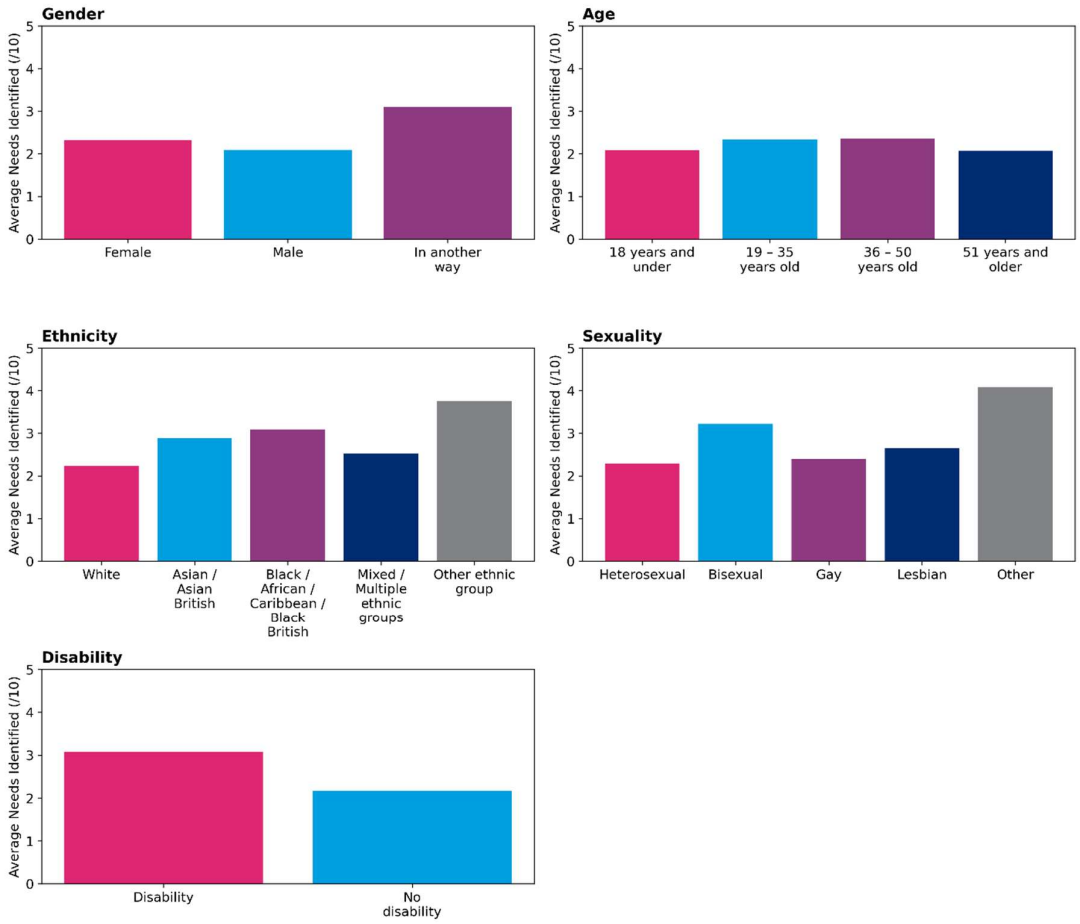
Table 1: *Independent variables – This table displays the number of clients within each category of the independent variables, along with the percentage of clients within that specific category.*



Graph 1: *The breakdown of the five demographics used within the quantitative statistics model used by this project.*

Needs Identified at Intake

Full descriptive statistics outlining the needs identified by victim/survivors at intake are displayed in the Appendix. The average number of needs for each demographic has been calculated and tabulated below. Certain marginalised communities across ethnicity, sexuality, and disability show a higher number of identified needs. This includes Black, Asian and racially minoritised victim/survivors; disabled victim/survivors; female victim/survivors; and bisexual victim/survivors.



Graph 2: *The average number of needs identified for each demographic out of the ten*

Disparities in needs were observed across ethnic groups. Victim/survivors from Asian/Asian British backgrounds reported elevated needs in employment, education, and training (26.4%), finance, benefits, and debt (48.8%), and housing (61.9%). Similarly, those from Black/African/Caribbean/Black British backgrounds showed higher levels of need in employment, education, and training (26.4%), finance, benefits, and debt (52.7%), and housing (70.7%). Victim/survivors from other ethnic backgrounds also demonstrated increased needs in these areas, particularly in employment, education, and training (41.4%), finance, benefits, and debt (63.6%), and housing (70.4%). Those from mixed/multiple ethnic groups showed elevated housing needs (66.1%). Additionally, victim/survivors under the age of 18 exhibited higher needs in employment, education, and training (28.2%).

Mental health needs were most prevalent among victim/survivors who identified as bisexual (74.8%), lesbian (69.9%), or gay (65.2%), as well as those with a disability (74.3%). Similarly, physical health needs were highest among victim/survivors with a disability (46.0%). Additional analysis and exploration could be undertaken to explore this further.

LGBT+ victim/survivors were more likely to identify needs around alcohol, drug misuse, employment, education, and training. Disabled victim/survivors were more likely to identify needs around alcohol, drug misuse, finance, benefits, and debt. Black, Asian, and racially minoritised victim/survivors were less likely to identify needs around alcohol. They were more likely to identify needs for employment, education and training, finance, benefits and debt and immigration. Victim/survivors aged 18 and under were most likely to have needs around employment, education, and training, and those aged 19-35 and 35-50 were also more likely to have this need than those aged 51+. Female victim/survivors and those that identify in another way were more likely to have housing needs than male victim/survivors.

Referral Routes

Descriptive statistics outlining the number and percentage of victim/survivors referred through each referral pathway is displayed in the appendix. The statistics show differences in referral pathways

among individuals with different identities. As expected, young people are more likely to be referred by children's social care. However, the largest differences were found in referrals through police and helplines for disabled victim/survivors and those victim/survivors from ethnic minorities.

Victim/survivors from Black/African/Caribbean/Black British (13.7%), Asian/Asian British (14.6%) backgrounds, and those with a disability (19.8%) were among the least likely to be referred through the police. In contrast, referrals through helplines were more common among Asian/Asian British victim/survivors (25.9%), Black/African/Caribbean/Black British victim/survivors (19.4%), those from mixed/multiple ethnic groups (14.9%), other ethnic groups (11.1%), and individuals with a disability (10.2%).

Additionally, a higher proportion of victim/survivors with a disability (9.6%) and those from mixed/multiple ethnic groups (10.6%) were referred through MARAC. Self-referrals were most common among victim/survivors who identified as lesbian (25.8%) and among those who identified as male (25.2%).

Multi-level model results

Length of Abuse

The intraclass correlation coefficient (ICC) was 0.033, suggesting that 3.3% of the variance in length of abuse experienced (in months) was attributable to differences between service providers. The marginal R^2 (fixed effects only) was 0.105, and the conditional R^2 (fixed and random effects) was 0.135, indicating that the fixed effects explained 10.5% of the variance, and the full model (including random effects) explained 13.5%. This suggests that the inclusion of random effects has improved the overall model fit supporting the use of a multilevel approach to account for clustering by service provider.

Several individual-level characteristics were significantly associated with the length of abuse. Gender was a significant predictor, with male victim/survivors reporting shorter durations of abuse compared to females (β = -7.80, 95% CI [-11.88, -3.72], $p < .001$). Age also had a significant effect. Compared to those aged 36 to 50 years (the reference group), individuals aged 19 to 35 reported significantly shorter abuse durations (β = -32.77, 95% CI [-34.64, -30.90], $p < .001$), as did those under 18 (β = -47.10, 95% CI [-52.73, -41.48], $p < .001$). In contrast, victim/survivors aged 51 and over experienced significantly longer durations of abuse (β = 43.79, 95% CI [40.78, 46.81], $p < .001$).

Ethnicity was another significant factor. Individuals identifying as Asian or Asian British reported significantly longer abuse durations compared to White individuals (β = 20.65, 95% CI 16.93, 24.38], $p < .001$), as did those identifying as Black, African, Caribbean, or Black British (β = 9.67, 95% CI 3.34, -15.99], $p = .003$). Other ethnic groups, including Mixed/multiple ethnic groups and Other ethnic group categories, did not differ significantly from the reference category.

Having a disability was associated with a significantly longer duration of abuse (β = 4.31, 95% CI [1.88, 6.73], $p < .001$). Sexual orientation was also a significant predictor. Compared to heterosexual individuals, those identifying as bisexual (β = -9.00, 95% CI [-15.98, -2.02], $p = .012$), gay (β = -13.85, 95% CI [-27.02, -0.67], $p = .039$), and lesbian (β = -15.37, 95% CI [-25.65, -5.09], $p = .003$) reported shorter durations of abuse.

Finally, the year the case was opened, centred around 2020, was negatively associated with the length of abuse (β = -1.76, 95% CI [-2.27, -1.25], $p < .001$), indicating that individuals referred more recently had experienced slightly shorter abuse durations. This is likely to be expected as those with longer length of abuse would be referred later.

Interaction Effects[1]

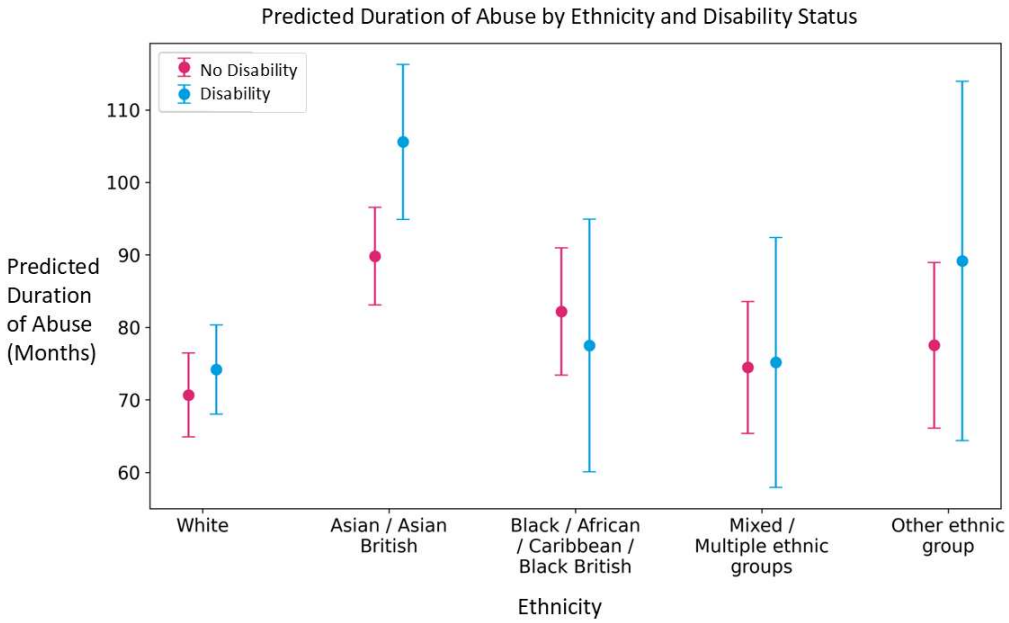
Interaction effects that were found to significantly influence length of abuse are listed below. Ethnicity and sexuality were not found to be significant:

Ethnicity and Disability

A significant interaction between ethnicity and disability indicated that Asian or Asian British victim/survivors with a disability experienced significantly longer durations of abuse than would be

[1] See Appendix 1 for cross-tabulations of the four variable pairs included as interaction effects in the multilevel models: ethnicity and sexuality, age and sexuality, ethnicity and age, and ethnicity and disability.

expected based on the independent effects of ethnicity and disability alone (β = 12.24, *p* = .018). Predicted values show this compounding effect (see Graph 1). Among those without a disability, Asian/Asian British individuals were estimated to have experienced 89.82 months of abuse (95% CI: 83.08, 96.56), compared to 70.67 months for White individuals. Among those with a disability, the difference was more pronounced with Asian or Asian British individuals with a disability expected to experience 105.58 months of abuse (95% CI: 94.89, 116.27), compared to 74.18 months for White individuals with a disability. This finding suggests a compounding effect, whereby the combination of being both Asian/Asian British and having a disability is associated with a substantially higher predicted duration of abuse than either identity alone would suggest.



Graph 3: *The Predicted Duration of Abuse (in Months) by Ethnicity and Disability Status. Error bars represent the 95% confidence level.*

Age and Ethnicity

There several significant interactions between age and ethnicity, indicating that the effect of age on length of abuse varied by ethnic group.

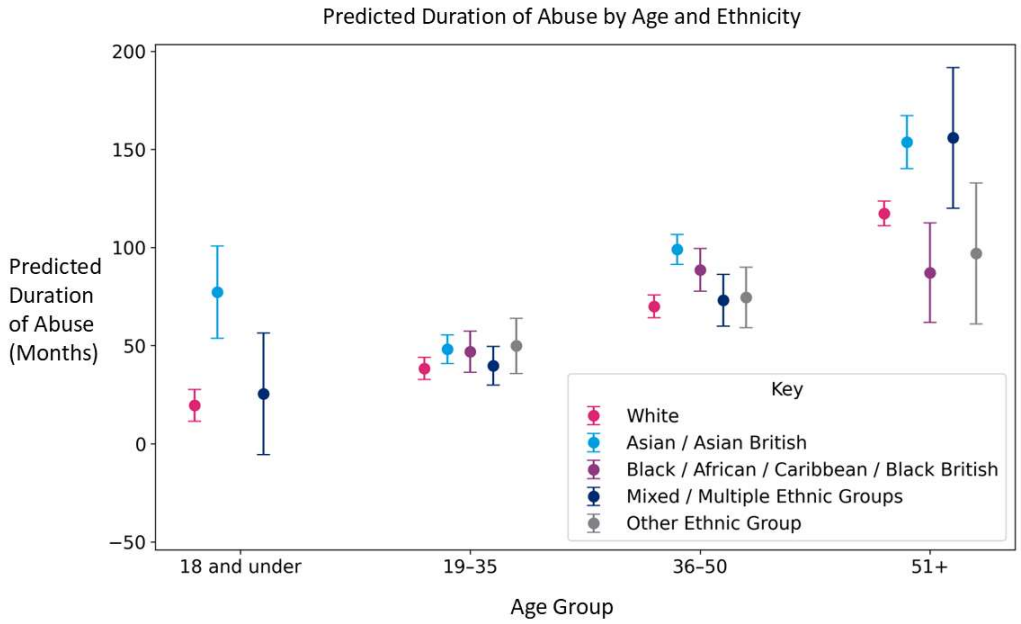
A significant interaction between age and ethnicity indicated that Asian or Asian British victim/survivors aged 19–35 experienced significantly shorter durations of abuse than would be expected based on the independent effects of age and ethnicity alone (β = -19.24, 95% CI [-26.73, -11.74], *p* < .001). Predicted values show this compounding effect (see Graph 2). Among Asian or Asian British victim/survivors aged 19–35, the predicted abuse duration was 48.19 months (95% CI: 40.83, 55.54), compared to 38.38 months for White victim/survivors of the same age.

However, this pattern reversed for younger victim/survivors: those under 18 who identified as Asian or Asian British experienced significantly longer abuse durations than expected based on the independent effects of age and ethnicity alone (β = 28.72, 95% CI [4.49, 52.96], *p* = .020). Predicted values show this compounding effect (see Graph 2). Among Asian or Asian British participants under 18, the predicted abuse duration was 77.30 months (95% CI: 53.80, 100.81), compared to 19.53 months for White individuals under 18.

A further significant interaction was observed for victim/survivors aged 51+ who identified as Black, African, Caribbean, or Black British. These individuals experienced substantially shorter durations of abuse than would be expected from the additive effects of age and ethnicity alone (β = -48.80, 95% CI [-75.48, -22.11], p < .001). Predicted values show this compounding effect (see Graph 2). Among Black victim/survivors aged 51+, the predicted duration was 87.17 months (95% CI: 61.84, 112.50), in contrast to 117.37 months among White counterparts.

These findings suggest that the intersection of age and ethnicity plays an important role in shaping the length of abuse, beyond the effects of each characteristic alone.

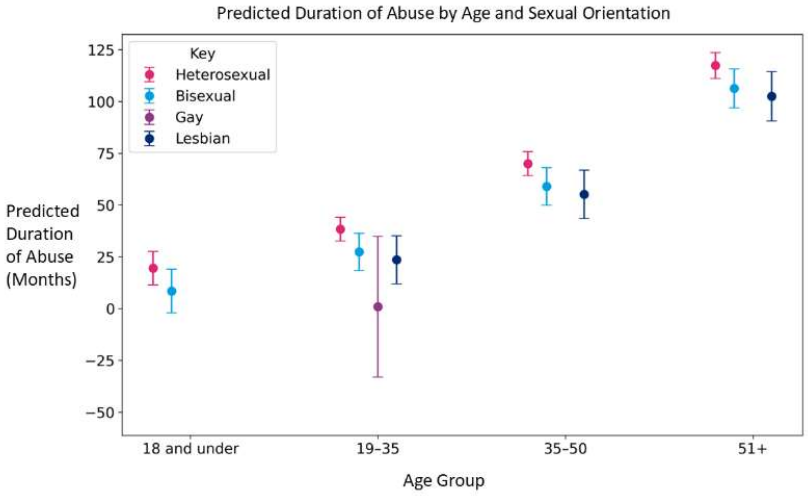
These results suggest that the relationship between age and length of abuse is moderated by ethnicity, underlining the importance of intersectional analysis when examining abuse trajectories.



Graph 4: *Predicted Duration of Abuse (in Months) by Age Group and Ethnicity. Error bars represent months of abuse with 95% confidence. Low sample sizes have not been included.*

Age and Sexuality

Graph 5: *Predicted Duration of Abuse (in Months) by Age Group and Sexual Orientation. Error bars represent months of abuse with 95% confidence.*



A significant interaction between age and sexual orientation indicated that older lesbian victim/survivors (aged 51+) experienced significantly shorter durations of abuse than would be expected based on the independent effects of age and sexual orientation alone (β = -51.29, 95% CI: -92.96, -9.63, p = .016). Predicted values illustrate this interaction (see Graph 3). Among heterosexual women aged 51+, the predicted duration of abuse was 117.37 months (95% CI: 111.10, 123.64), compared to 102.52 months for lesbian women in the same age group (95% CI: 90.59, 114.45). This finding suggests a mitigating effect, whereby identifying as lesbian is associated with a notably reduced predicted duration of abuse among older women, in contrast to the otherwise strong association between older age and longer abuse duration.

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	19.53 (11.46, 27.61) *n = 669*	8.49 (-2.09, 19.08) *n = 28*	*n = 0*	*n = 7**

19–35	38.38 (32.69, 44.07) *n = 15691*	27.34 (18.36, 36.32) *n = 275*	0.96 (-33.04, 34.96) *n = 10*	23.52 (11.91, 35.13) *n = 113*
35–50	70.02 (64.23, 75.80) *n = 9365*	58.98 (49.90, 68.05) *n = 117*	*n = 6**	55.16 (43.51, 66.82) *n = 71*
51+	117.37 (111.10, 123.64) *n = 2865*	106.33 (96.88, 115.78) *n = 14*	*n = 3**	102.52 (90.59, 114.45) *n = 15*

Table 2: *Predicted Duration of Abuse (in Months) by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.018, suggesting that 1.8% of the variance in abuse duration was attributable to differences between identity strata.

The intraclass correlation coefficient (ICC) for the identity strata was 0.19 before adding in the fixed effects, indicating that approximately 19% of the variance in abuse duration was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0.018. This suggests that 1.8% of the variance in abuse duration remained attributable to between group differences, with most of the variance explained by individual identity characteristics. The ICC for service-provider was 0.032, suggesting that 3.2% of the variance in abuse duration was attributable to differences between service providers.

Four demographic strata were found to have random intercepts significantly greater than zero, indicating that individuals in these groups experienced significantly longer durations of abuse than predicted by the fixed effects alone. This included:

White, heterosexual females aged 51 and older with a disability – the estimated random intercept for this stratum was 16.22 months (*SE* = 2.86,95% CI: 10.61 to 21.82) suggesting that members of this group experienced, on average, abuse durations over 16 months longer than the predicted estimate of 108.7 months. (n = 858)
White, heterosexual females aged 51 and older without a disability - the estimated random intercept for this stratum was 9.55 months (*SE* = 2.29, 95% CI: 5.06 to 14.03) suggesting that members of this group experienced, on average, abuse durations over 9 months longer than the predicted estimate of 70.5 months (n = 1798).
Asian/Asian British, heterosexual females aged 51 and older without a disability - the estimated random intercept for this stratum was 12.25 months (*SE* = 6.24, 95% CI: 0.01 to 24.48) suggesting that members of this group experienced, on average, abuse durations over 12 months longer than the predicted value of 132.5 months. The wide confidence interval reflects the relatively small sample size (n = 95), indicating greater uncertainty around the estimate.
Asian/Asian British, heterosexual females aged 36-50 with a disability - the estimated random intercept for this stratum was 12.23 months (*SE* = 6.02, 95% CI: 0.42 to 24.03) suggesting that members of this group experienced, on average, abuse durations over 12 months longer than the predicted estimate of 100.6 months. The wide confidence interval reflects the relatively small sample size (n = 107), indicating greater uncertainty around the estimate.

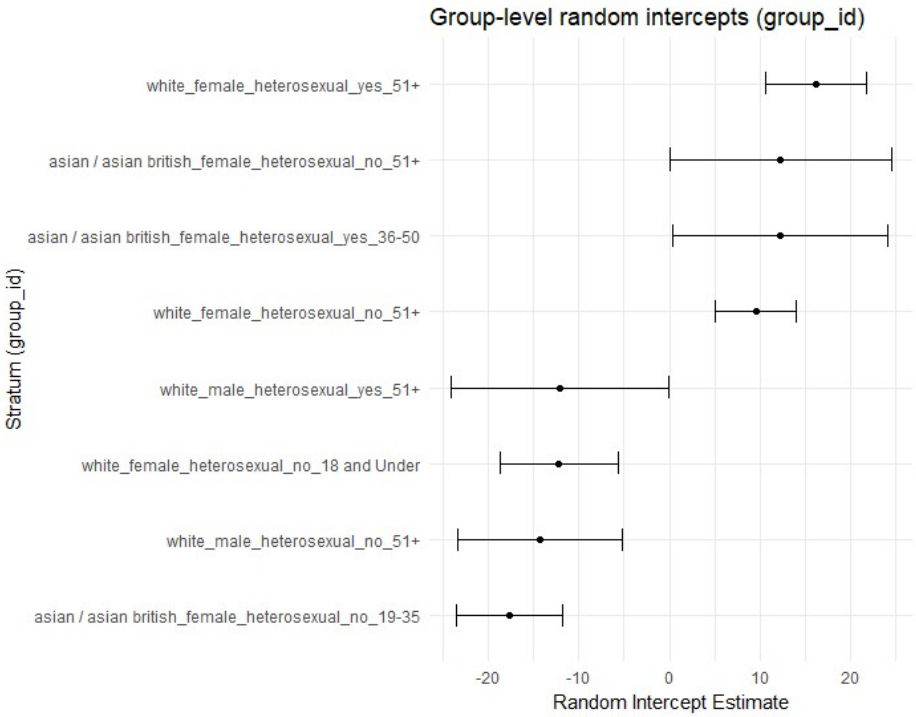
Four demographic strata were found to have random intercepts significantly less than zero, indicating that individuals in these groups experienced significantly shorter durations of abuse than predicted by the fixed effects alone. This included:

White, heterosexual females aged 18 and under without a disability – the estimated random intercept for this stratum was -12.17 months (*SE* = 3.36, 95% CI: -18.75 to -5.59) suggesting that members of this group experienced, on average, abuse durations 12 months less than the predicted estimate of 32.9 months (n = 551).
White, heterosexual males aged 51 and older with a disability - the estimated random intercept for this stratum was -12.07 months (*SE* = 6.12, 95% CI: -24.06 to -0.07) suggesting that members of this group experienced, on average, abuse durations 12 months less than the predicted estimate of

102.7 months. The wide confidence interval reflects the relatively small sample size (n = 101), indicating greater uncertainty around the estimate.

White, heterosexual males aged 51 and older without a disability - the estimated random intercept for this stratum was -14.24 months (*SE* = 4.63, 95% CI: -23.32 to -5.16) suggesting that members of this group experienced, on average, abuse durations 14 months less than the predicted estimate of 99.3 months (n = 229)..

Asian/Asian British, heterosexual females aged 19-35 without a disability - the estimated random intercept for this stratum was -17.65 months (*SE* = 2.97, 95% CI: -23.33 to -5.16) suggesting that members of this group experienced, on average, abuse durations 17 months less than the predicted estimate of 66.5 months (n = 783).



Graph 6: *Demographic groups with their random intercepts relating to expected durations of abuse. Those demographics with random intercepts below zero experienced shorter durations of abuse than the overall model prediction. Those demographics with random intercepts above zero experienced longer durations of abuse than the overall model prediction.*

Risk Profile

Risk Profile at Intake

A multilevel model was used to examine the relationships between victim/survivors' identities and the risk identified at intake using the DASH RIC (a higher number of ticks corresponds to a higher level of risk), while accounting for clustering at the service-provider level. The intraclass correlation coefficient (ICC) was 0.213, suggesting that 21.3% of the variance in abuse duration was attributable to differences between service providers. The marginal R^2 (fixed effects only) was 0.017, and the conditional R^2 (fixed and random effects) was 0.232, indicating that the fixed effects explained 1.7% of the variance, and the full model (including random effects) explained 23.2%. This suggests that the inclusion of random effects has improved the overall model fit supporting the use of a multilevel approach to account for clustering by service provider.

Several individual-level characteristics were significantly associated with the number of ticks on the DASH at intake. Gender was a significant predictor, with male victim/survivors having a lower number of ticks on the DASH at intake compared to females (β = -.81, 95% CI [-1.05, -0.57], $p < .001$). Age also had a significant effect. Compared to those aged 36 to 50 years (the reference group), individuals aged 19 to 35 had a significantly higher number of ticks on the DASH at intake (β = 0.44, 95% CI [0.33, 0.55], $p < .001$), whereas those aged 51 and over has a significantly lower number of ticks on the DASH at intake (β =-.84, 95% CI [-1.01, -0.66], $p < .001$). Under 18 did not significantly differ from the reference category ($p = .98$)

Ethnicity was another significant factor. Individuals identifying as Asian or Asian British had a significantly lower number of ticks on the DASH at intake compared to White individuals (β = -1.04, 95% CI [-1.25, -0.83], $p < .001$), as did those identifying as Black, African, Caribbean, or Black British (β = -1.11, 95% CI [-1.46, -0.75], $p = .003$). Ethnic groups, including Mixed/multiple ethnic groups ($p = .96$) and Other ethnic groups ($p = .08$), did not differ significantly from the reference category.

Having a disability was associated with a significantly higher number of ticks on the DASH at intake (β =.47, 95% CI [0.33, 0.61], $p < .001$). Sexual orientation was also a significant predictor. Compared to heterosexual individuals, those identifying as bisexual had a significantly higher number of ticks on the DASH at intake (β = .68, 95% CI [0.28, 1.09], $p < .001$). Risk at intake did not differ significantly for victim/survivors who identified as lesbian ($p = .342$) or gay ($p = .188$) from the reference category.

Finally, the year the case was opened, centred around 2020, was negatively associated with the number of ticks on the DASH at intake (β = -.12, 95% CI [-0.15, -0.09], $p < .001$), indicating that individuals referred more recently had a lower number of ticks on the DASH at intake.

Interaction Effects

Interaction effects that were found to significantly influence risk profile (ticks on DASH RIC) at intake are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Ethnicity and disability
- Age and ethnicity

Age and Sexuality

A significant interaction between age and sexuality indicated that gay victim/survivors aged 19-35 years had a higher level of risk on intake than would be expected based on the independent effects of age and sexuality alone (β = 8.00, 95% CI [3.51, 12.49], $p < .001$). Predicted values show this compounding effect (see Graph 5). Among those aged 36-50 years old (reference category), gay victim/survivors were estimated to have 6.57 number of ticks on the DASH at intake (95% CI: 3.18, 9.96), compared to 10.67 ticks for heterosexual individuals. Among those aged 19-35 years, the difference was more pronounced for gay victim/survivors with them expected to have 15.04 ticks (95% CI: 11.89, 18.19), compared to 11.14 ticks for heterosexual victim/survivors aged 19-35 years. This finding suggests a compounding effect, whereby the combination of being both gay and 19-35 years old is associated with a higher predicted level of risk at intake than either identity alone would suggest (however, the numbers are low).

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	10.71 (9.83, 11.58) n = 669	12.11 (10.36, 13.86) n = 28	n = 0	n = 7*
19–35	11.14 (10.33, 11.95) n = 15691	11.60 (10.65, 12.56) n = 275	15.04 (11.89, 18.19) n = 10	11.18 (10.04, 12.33) n = 113
35–50	10.67 (9.86, 11.48) n = 9365	11.69 (10.55, 12.82) n = 117	n = 6*	11.32 (10.03, 12.61) n = 71
51+	9.81 (8.99, 10.64) n = 2865	8.79 (6.32, 11.25) n = 14	n = 3*	11.17 (8.80, 13.55) n = 15

Table 3: *Predicted Number of Ticks on DASH by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low and is therefore not represented within the corresponding graph.*

Intersectional Identity Analysis[2]

The intraclass correlation coefficient (ICC) for the identity strata was 0.028 before adding in the fixed effects, indicating that approximately 2.8% of the variance in the number of ticks on the DASH at intake was attributable to differences between identity strata. After including the fixed effects, therefore,

[2] Full details of the analysis are available in Appendix 2

adjusting for individual identity characteristics, the ICC for identity strata decreased to 0.001. This suggests that 0.1% of the variance in the number of ticks on the DASH at intake remained attributable to between group differences, with most of the variance explained by individual identity characteristics. The ICC for service-provider was 0.213, suggesting that 21.3% of the variance in the number of ticks on the DASH at intake was attributable to differences between service providers.

One demographic stratum was found to have random intercepts significantly lower than zero, indicating that individuals in these groups had a lower number of ticks on the DASH at intake than predicted by the fixed effects alone. This was:

> **White, heterosexual females aged 51 and older with a disability** – the estimated random intercept for this stratum was -0.21 ticks (*SE* = 0.11,95% CI: -0.42 to 0.00) suggesting that members of this group experienced, on average, 0.21 fewer ticks on the DASH at intake than the predicted estimate of 10.2 (n = 858).

Change In Risk Profile from Intake to Exit

The number of ticks on the Dash RIC are recorded in Insights at intake and exit, allowing for an analysis in the change in risk profile. A positive value indicates a reduction in risk, negative values an increase, and zero indicating no change).

There was significant variability in change in risk scores between service providers, with an intraclass correlation coefficient (ICC) of .309, indicating that 30.9% of the variance in risk change was attributable to differences between services. The random intercept variance was 5.29 (SD = 2.30), and the residual variance was 11.83 (SD = 3.44). The marginal R^2, representing variance explained by fixed effects alone, was .017, while the conditional R^2, representing variance explained by both fixed and random effects, was .232. This suggests that individual-level predictors explained a small portion of the variance, but that accounting for service-level clustering improved model fit supporting the use of a multilevel approach to account for clustering by service provider.

Several individual-level characteristics were significantly associated with changes in risk. Gender was a significant predictor, with male victim/survivors showing a smaller reduction in risk compared to females (β = -0.34, 95% CI [-0.61, -0.07], p = .014). Age also showed some effects: compared to the reference group (aged 36–50), those aged 19–35 experienced a greater reduction in risk (β = 0.13, 95% CI [0.00, 0.25], p = .043). No significant differences were observed for individuals under 18 (p = .426) or over 51 (p = .617).

Ethnicity was a significant predictor for some groups. Compared to White victim/survivors, those identifying as from an “Other ethnic group” experienced a significantly greater reduction in risk (β = 0.69, 95% CI [0.13, 1.26], p = .016). No significant differences were found for individuals identifying as Asian/Asian British (p = .87), Black/African/Caribbean/Black British (p = .32), or Mixed/multiple ethnic groups (p = .44).

Victim/survivors who reported having a disability experienced a significantly smaller reduction in risk compared to those without a disability (β = -0.18, 95% CI [-0.33, -0.02], p = .028).

Sexual orientation was not significantly associated with change in risk, with no statistically significant differences between heterosexual individuals and those identifying as bisexual (p = .41), gay (p = .59), or lesbian (p = .37).

Finally, the year the case was opened, centred around 2020, was negatively associated with risk reduction (β = -0.09, 95% CI [-0.12, -0.05], p < .001), suggesting that individuals referred more recently experienced smaller reductions in DASH risk scores.

Interaction Effects

Interaction effects that were found to significantly influence change in risk profile from intake to exit are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Age and ethnicity
- Age and sexuality

Ethnicity and Disability
A significant interaction between ethnicity and disability indicated that Black or Black British victim/survivors with a disability experienced significantly smaller reductions in risk (i.e., less positive change in DASH score) than would be expected based on the independent effects of ethnicity and disability alone (β = −1.17, 95% CI [-2.27, -0.07], *p* = .036). This suggests a compounding disadvantage where the combined effect of being both Black or Black British and having a disability is associated with poorer improvements in risk profile.

Predicted values highlight this interaction effect (see Graph 7). Among those without a disability, Black or Black British individuals had an estimated average reduction in 3.11 ticks on the DASH RIC (95% CI: 2.15, 4.07), slightly greater than White individuals who had an estimated average reduction of 2.76 ticks on the DASH RIC (95% CI: 1.89, 3.64). However, among those with a disability, Black or Black British individuals showed a substantially smaller reduction in ticks on the DASH RIC with an estimated average reduction of 1.81 ticks (95% CI: 0.49, 3.13), compared to White individuals with a disability with an estimated average reduction of 2.63 ticks (95% CI: 1.75, 3.52).

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	2.76 (1.89, 3.64) n = 22239	2.79 (1.89, 3.68) n = 1588	3.11 (2.15, 4.07) n = 469	2.61 (1.63, 3.58) n = 429	3.34 (2.29, 4.40) n = 220
Yes	2.63 (1.75, 3.52) n = 3869	2.35 (1.33, 3.37) n = 262	1.81 (0.49, 3.13) n = 80	2.00 (0.69, 3.31) n = 83	4.02 (2.12, 5.92) n = 39

Table 4: *Predicted Change in Number of Ticks on DASH from Intake to Exit by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Intersectional Identity Analysis
The intraclass correlation coefficient (ICC) for the identity strata was less than 0.001 before adding in the fixed effects, indicating that approximately 0.1% of the variance in the change in number of ticks on the DASH from intake to exit was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in the change in number of ticks on the DASH from intake to exit across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.30, suggesting that 3.0% of the variance in the in the change in number of ticks on the DASH from intake to exit was attributable to differences between service providers.

Client Reported Outcomes

Safety

Self-reported perceptions of safety at closure were measured on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) in response to the statement “I feel safer.” There was modest variability in perceived safety across services, with an intraclass correlation coefficient (ICC) of .077, indicating that 7.7 % of the variance in safety scores was attributable to differences between service providers. The random intercept variance was 0.035 (SD = 0.19), and the residual variance was 0.515 (SD = 0.72). The marginal R^2, representing variance explained by fixed effects alone, was .005, while the conditional R^2, representing variance explained by both fixed and random effects, was .068. These values indicate that individual-level characteristics explained a small proportion of variance in safety, but that accounting for clustering by service slightly improved the model fit supporting the use of a multilevel approach to account for clustering by service provider.

Several individual-level characteristics were significantly associated with perceived safety. Gender was a significant predictor, with male victim/survivors reporting lower feelings of safety compared to females (β = -0.08, 95% CI [-0.14, -0.02], *p* = .005). Age also showed a significant effect: individuals aged 19–35 reported slightly higher safety compared to those aged 36–50 (β = 0.04, 95% CI [0.01, 0.06], *p* = .006). No significant differences were observed for those under 18 (*p* = .246) or over 51 (*p* = .844).

Ethnicity was a significant predictor for some groups. Compared to White victim/survivors, those identifying as Asian or Asian British reported higher feelings of safety (β = 0.13, 95% CI [0.08, 0.18], $p <$ .001), as did those identifying as Black, African, Caribbean, or Black British (β = 0.11, 95% CI [0.02, 0.19], p = .013), and those from another ethnic group (β = 0.17, 95% CI [0.05, 0.29], p = .006). No significant differences were found for individuals identifying as Mixed or multiple ethnic groups (p = .244).

Disability was not a significant predictor of perceived safety (p = .089).

Regarding sexual orientation, bisexual victim/survivors reported significantly higher feelings of safety compared to heterosexual individuals (β = 0.12, 95% CI [0.02, 0.23], p = .016). No significant differences were observed for those identifying as gay (p = .904) or lesbian (p = .202).

Finally, year of case opening (centred around 2020) was negatively associated with safety (β = -0.01, 95% CI [-0.016, -0.0004], p = .039), indicating that more recent referrals were associated with slightly lower perceptions of safety at exit.

Interaction Effects

Interaction effects that were found to significantly influence victim/survivors self-reported improvements in safety at case closure are listed below. Age and ethnicity were not found to be significant.

Ethnicity and Sexuality

A significant interaction between sexual orientation and ethnicity indicated that bisexual Asian or Asian British victim/survivors reported significantly lower perceived improvements in safety than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = −0.55, 95% CI [−1.00, −0.11], p = .015). This suggests a compounding disadvantage, where the intersection of being both bisexual and Asian or Asian British is associated with lower self-reported safety at case closure.

Predicted values illustrate the significant interaction between bisexual orientation and Asian/Asian British ethnicity, among heterosexual individuals, Asian or Asian British victim/survivors reported a high predicted safety score of 4.37 (95% CI [4.28, 4.46]), slightly higher than White heterosexuals at 4.23 (95% CI [4.15, 4.31]). However, among bisexual victim/survivors, the predicted safety score for Asian or Asian British individuals dropped to 3.97 (95% CI [3.53, 4.40]), in contrast to White bisexual victim/survivors who reported a higher predicted score of 4.38 (95% CI [4.25, 4.52]). This represents a marked reversal of the main effect trend and highlights the disadvantage that can be faced at the intersection of minoritised sexual and ethnic identities.

Sexuality	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
Heterosexual	4.23 (4.15, 4.31) n = 25505	4.37 (4.28, 4.46) n = 1817	4.34 (4.22, 4.45) n = 526	4.28 (4.16, 4.40) n = 493	4.40 (4.26, 4.55) n = 249
Bisexual	4.38 (4.25, 4.52) n = 377	3.97 (3.53, 4.40) n = 23	4.46 (3.86, 5.06) n = 18	4.16 (3.53, 4.80) n = 13	n = 3*
Gay	4.15 (3.64, 4.65) n = 19	n = 0	n = 0	n = 0	n = 0
Lesbian	4.33 (4.15, 4.51) n = 193	n = 6*	n = 2*	n = 2*	n = 3*

Table 5: *Predicted Perceived Improvement in Safety by Ethnicity and Sexuality. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Ethnicity and Disability

A significant interaction between ethnicity and disability indicated that Black or Black British victim/survivors with a disability reported significantly lower improvements in perceived safety at case closure than would be expected based on the independent effects of ethnicity and disability alone (β = −0.30, 95% CI [−0.56, −0.04], p = .022). This suggests a compounding disadvantage where the

intersection of being both Black or Black British and having a disability is associated with less positive perceptions of safety following support.

Among those without a disability, Black or Black British individuals had an average predicted safety score of 4.37 (95% CI [4.26, 4.49]), which was slightly higher than the score for White individuals (4.23, 95% CI [4.15, 4.31]). However, among those with a disability, the predicted score for Black or Black British victim/survivors dropped to 4.05 (95% CI [3.80, 4.30]), in contrast to White victim/survivors with a disability who reported a slightly higher score of 4.20 (95% CI [4.12, 4.29]) when compared to Black or Black British victim/survivors with a disability.

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	4.23 (4.15, 4.31) n = 22239	4.36 (4.27, 4.45) n = 1588	4.37 (4.26, 4.49) n = 469	4.31 (4.19, 4.43) n = 429	4.39 (4.24, 4.54) n = 220
Yes	4.20 (4.12, 4.29) n = 3869	4.32 (4.17, 4.46) n = 262	4.05 (3.80, 4.30) n = 80	4.08 (3.86, 4.31) n = 83	4.44 (4.04, 4.84) n = 39

Table 6: *Predicted Perceived Improvement in Safety by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Sexuality

A significant interaction between age and sexual orientation was observed in relation to perceived improvements in safety at case closure for clients (β = −1.29, 95% CI [−2.37, −0.22], p = .018). Specifically, the interaction between being aged 19–35 and identifying as gay was associated with a significantly lower perceived improvement in safety compared to heterosexual individuals in the same age group. This suggests that for young gay women, perceived safety may not improve as much through support services.

Predicted values further illustrate this interaction effect. Among heterosexual women, perceived safety scores were relatively consistent across age groups, with those aged 36–50 reporting an average score of 4.23 (95% CI [4.15, 4.31]) and those aged 19–35 reporting a slightly higher score of 4.27 (95% CI [4.19, 4.35]). However, among gay women, the pattern differed notably. Those aged 36–50 reported the predicted score of 4.60 (95% CI [3.89, 5.30]), while those aged 19–35 reported a markedly lower score of 3.34 (95% CI [2.53, 4.16]). These findings should be interpreted with caution due to the very small number of clients in this subgroup, as only individuals who identified as female were included in the sample, and only a small proportion identified as gay (n = 10).

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	4.27 (4.16, 4.38) n = 669	4.33 (3.92, 4.75) n = 28	n = 0	n = 7*
19–35	4.27 (4.19, 4.35) n = 15691	4.39 (4.24, 4.54) n = 275	3.34 (2.53, 4.16) n = 10	4.30 (4.06, 4.53) n = 113
35–50	4.23 (4.15, 4.31) n = 9365	4.39 (4.18, 4.60) n = 117	4.60 (3.89, 5.30) n = 6*	4.40 (4.13, 4.68) n = 71
51+	4.24 (4.15, 4.32) n = 2865	4.03 (3.55, 4.50) n = 14	n = 3*	4.26 (3.68, 4.84) n = 15

Table 7: *Predicted Perceived Improvement in Safety by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.011 before adding in the fixed effects, indicating that approximately 1.1% of the variance in perceived level of safety was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in perceived level of safety across identity strata groups when accounting for

individual-level factors. The ICC for service-provider was 0.06, suggesting that 6.0% of the variance in the in perceived level of safety was attributable to differences between service providers.

Wellbeing

Self-reported perceptions of improved wellbeing at case closure were measured on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) in response to the statement *"My wellbeing has improved."* There was modest variability in perceived improvements in wellbeing across services, with an intraclass correlation coefficient (ICC) of .078, indicating that 7.8% of the variance in wellbeing scores was attributable to differences between service providers. The random intercept variance was 0.040 (SD = 0.20), and the residual variance was 0.572 (SD = 0.76). The marginal R^2, representing variance explained by fixed effects alone, was .007, while the conditional R^2, representing variance explained by both fixed and random effects, was .071. These values indicate that individual-level characteristics explained a small proportion of the variance in wellbeing, but that accounting for clustering by service slightly improved the model fit, supporting the use of a multilevel approach.

Several individual-level characteristics were significantly associated with perceived improvements in wellbeing. Gender was a significant predictor, with male victim/survivors reporting lower improvements in wellbeing compared to females (β = -0.15, 95% CI [-0.21, -0.09], $p < .001$). Age was not a significant predictor. Individuals aged 19–35 ($p = .056$), under 18 ($p = .332$), or aged 51 and older ($p = .769$) did not report significantly different levels of improved wellbeing compared to those aged 36–50.

Ethnicity was a significant predictor for several groups. Compared to White victim/survivors, those identifying as Asian or Asian British (β = 0.09, 95% CI [0.04, 0.14], $p < .001$), Black, African, Caribbean, or Black British (β = 0.13, 95% CI [0.04, 0.22], $p = .004$), and those from another ethnic group (β = 0.14, 95% CI [0.01, 0.27], $p = .032$) reported significantly higher improvements in wellbeing. No significant differences were found for individuals identifying as Mixed or multiple ethnic groups ($p = .960$).

Disability was a significant predictor of improved wellbeing. Victim/survivors who reported having a disability experienced lower improvement in wellbeing compared to those without a disability (β = -0.08, 95% CI [-0.11, -0.04], $p < .001$).

Sexual orientation was also a significant factor. Bisexual victim/survivors reported higher perceived improvements in wellbeing compared to heterosexual individuals (β = 0.15, 95% CI [0.04, 0.25], $p = .007$). No significant differences were found for those identifying as gay ($p = .232$) or lesbian ($p = .189$).

Finally, year of case opening (centred around 2020) was negatively associated with wellbeing (β = -0.01, 95% CI [-0.022, -0.005], $p = .001$), indicating that more recent referrals were associated with slightly lower improvements in wellbeing at case closure.

Interaction Effects

Interaction effects that were found to significantly influence victim/survivors self-reported improvements in wellbeing at case closure are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Ethnicity and disability
- Age and sexuality

Age and Ethnicity

A significant interaction between age and ethnicity indicated that the relationship between age and perceived improvements in wellbeing varied across ethnic groups. Notably, young women (18 and under) from an "Other" ethnic group reported significantly lower improvements in wellbeing than would be expected based on the independent effects of age and ethnicity alone (β = −1.10, 95% CI [−1.87, −0.32], $p = .006$).

Predicted values further illustrate this interaction effect. Among women aged 36–50, those from an "Other" ethnic group reported the highest predicted wellbeing score of 4.38 (95% CI [4.16, 4.61]), exceeding the average for White women in the same age group (4.12, 95% CI [4.04, 4.21]). However, among the youngest group (18 and under), this trend reversed: victim/survivors from an "Other" ethnic group reported a markedly lower predicted score of 3.34 (95% CI [2.60, 4.08]), compared to 4.18 (95%

CI [4.06, 4.29]) among White victim/survivors. This represents a significant divergence in wellbeing outcomes, highlighting potential vulnerabilities among the youngest women from "Other" ethnic backgrounds.

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	4.18 (4.06, 4.29) n = 628	4.30 (3.95, 4.65) n = 42	n = 6*	4.09 (3.64, 4.54) n = 23	n = 6*
19–35	4.15 (4.06, 4.23) n = 14486	4.28 (4.18, 4.39) n = 900	4.26 (4.11, 4.42) n = 267	4.14 (4.00, 4.28) n = 321	4.23 (4.04, 4.42) n = 130
36–50	4.12 (4.04, 4.21) n = 8307	4.19 (4.08, 4.29) n = 766	4.27 (4.11, 4.42) n = 241	4.17 (3.99, 4.35) n = 151	4.38 (4.16, 4.61) n = 106
51+	4.12 (4.03, 4.21) n = 2687	4.20 (4.01, 4.39) n = 142	4.28 (3.96, 4.59) n = 35	3.91 (3.35, 4.47) n = 17	4.45 (3.89, 5.02) n = 17

Table 8: *Predicted Wellbeing Score by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.013 before adding in the fixed effects, indicating that approximately 1.3% of the variance in the perceived level of wellbeing was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in the perceived level of wellbeing across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.06, suggesting that 6.0% of the variance in the in perceived wellbeing was attributable to differences between service providers.

Quality of Life

Self-reported perceptions of improved quality of life at case closure were measured on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) in response to the statement “My quality of life has improved.” There was modest variability in perceived improvements in quality of life across services, with an intraclass correlation coefficient (ICC) of .076, indicating that 7.6% of the variance in quality-of-life scores was attributable to differences between service providers. The random intercept variance was 0.043 (SD = 0.21), and the residual variance was 0.607 (SD = 0.78). The marginal R^2, representing variance explained by fixed effects alone, was .007, while the conditional R^2, representing variance explained by both fixed and random effects, was .073. These values suggest that individual-level characteristics explained a small proportion of variance in quality of life, though accounting for clustering by service modestly improved model fit, supporting the use of a multilevel approach.

Several individual-level characteristics were significantly associated with perceived improvements in quality of life. Gender was a significant predictor, with male victim/survivors reporting lower improvements in quality of life compared to females (β = -0.14, 95% CI [-0.21, -0.08], $p < .001$). Age was a significant predictor for those aged 19–35, who reported slightly higher improvements than those aged 36–50 (β = 0.04, 95% CI [0.01, 0.07], $p = .004$). Age was not a significant predictor for individuals under 18 ($p = .193$) or those aged 51 and older ($p = .234$).

Ethnicity was also a significant predictor for some groups. Compared to White victim/survivors, those identifying as Asian or Asian British (β = 0.08, 95% CI [0.03, 0.13], $p = .003$) and Black, African, Caribbean, or Black British (β = 0.10, 95% CI [0.01, 0.20], $p = .026$) reported significantly higher improvements in quality of life. Ethnicity was not a significant predictor for those identifying as Mixed or multiple ethnic groups ($p = .588$) or from another ethnic group ($p = .203$).

Disability was a significant negative predictor of improved quality of life. Victim/survivors who reported having a disability experienced lower improvement in quality of life compared to those who did not report having a disability (β = -0.07, 95% CI [-0.10, -0.03], $p < .001$).

Sexual orientation was also a significant factor. Bisexual victim/survivors reported higher perceived improvements in quality of life compared to heterosexual individuals (β = 0.16, 95% CI [0.05, 0.27], p = .004). No significant differences were found for those identifying as gay (p = .512) or lesbian (p = .133).

Finally, year of case opening (centred around 2020) was negatively associated with perceived improvement in quality of life (β = -0.01, 95% CI [-0.021, -0.004], p = .003), suggesting that more recent referrals were associated with slightly lower reported improvements at case closure.

Interaction Effects

Interaction effects that were found to significantly influence victim/survivors self-reported improvements in quality of life at case closure are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Age and sexuality

Ethnicity and Disability

A significant interaction between ethnicity and disability indicated that Black or Black British victim/survivors with a disability reported significantly lower improvements in perceived quality of life at case closure than would be expected based on the independent effects of ethnicity and disability alone (β = −0.31, 95% CI [−0.59, −0.02], p = .033). This suggests a compounding disadvantage where the intersection of being both Black or Black British and having a disability is associated with less positive perceptions of quality-of-life following support.

Predicted values further illustrate this interaction effect. Among those without a disability, Black or Black British individuals had an average predicted quality of life score of 4.19 (95% CI [4.06, 4.32]), which was higher than the score for White individuals (4.05, 95% CI [3.96, 4.13]). However, among those with a disability, the predicted score for Black or Black British victim/survivors dropped to 3.83 (95% CI [3.55, 4.11]), in contrast to White victim/survivors with a disability who reported a slightly higher score when comparted to Black or Black British victim/survivors with a disability of 4.00 (95% CI [3.90, 4.09]).

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	4.05 (3.96, 4.13) n = 22239	4.15 (4.05, 4.25) n = 1588	4.19 (4.06, 4.32) n = 469	4.08 (3.95, 4.22) n = 429	4.11 (3.95, 4.28) n = 220
Yes	4.00 (3.90, 4.09) n = 3869	3.97 (3.81, 4.12) n = 262	3.83 (3.55, 4.11) n = 80	3.93 (3.69, 4.18) n = 83	4.10 (3.67, 4.53) n = 39

Table 9: *Predicted Quality of Life by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Ethnicity

A significant interaction between age and ethnicity indicated that the relationship between age and perceived improvements in quality of life varied across ethnic groups. Specifically, young women (18 and under) from an “Other” ethnic group reported significantly lower improvements in quality of life than would be expected based on the independent effects of age and ethnicity alone (β = −1.16, 95% CI [−1.96, −0.37], p = .004).

Predicted values further illustrate this interaction effect. Among women aged 36–50, those from an “Other” ethnic group reported the highest predicted quality of life score of 4.17 (95% CI [3.93, 4.40]), slightly higher than the average for White women in the same age group (4.05, 95% CI [3.96, 4.14]). However, among the youngest group (18 and under), this trend sharply reversed: victim/survivors from an “Other” ethnic group had a markedly lower predicted score of 3.07 (95% CI [2.31, 3.84]), compared to 4.12 (95% CI [3.99, 4.24]) among their White counterparts. This interaction points to a specific disadvantage faced by the youngest women from “Other” ethnic backgrounds. These findings should be interpreted with caution due to the very small number of clients aged 18 and under reported being from an “Other” ethnic group (n = 6).

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	4.12 (3.99, 4.24) n = 628	4.09 (3.73, 4.45) n = 42	n = 6*	4.08 (3.61, 4.54) n = 23	n = 6*
19–35	4.08 (4.00, 4.17) n = 14486	4.21 (4.10, 4.32) n = 900	4.20 (4.04, 4.35) n = 267	4.09 (3.95, 4.24) n = 321	4.18 (3.98, 4.37) n = 130
36–50	4.05 (3.96, 4.14) n = 8307	4.10 (3.99, 4.21) n = 766	4.15 (4.00, 4.31) n = 241	4.10 (3.91, 4.28) n = 151	4.17 (3.93, 4.40) n = 106
51+	4.02 (3.93, 4.12) n = 2687	4.08 (3.88, 4.28) n = 142	4.14 (3.81, 4.47) n = 35	4.04 (3.46, 4.62) n = 17	4.18 (3.60, 4.76) n = 17

Table 10: *Predicted Quality of Life by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.013 before adding in the fixed effects, indicating that approximately 1.3% of the variance in the perceived quality of life was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in the perceived quality of life across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.06, suggesting that 6.0% of the variance in the in perceived quality of life was attributable to differences between service providers.

Level of Abuse

Level of Physical Abuse at Intake

Severity of physical abuse reported at intake was measured on a 4-point ordinal scale (1 = no physical abuse, 2 = standard level, 3 = moderate level, 4 = high level), with higher scores indicating greater severity. There was moderate variability in physical abuse scores across services, with an intraclass correlation coefficient (ICC) of .134, indicating that 13.4% of the variance in physical abuse scores was attributable to differences between service providers. The random intercept variance was 0.223 (SD = 0.47), and the residual variance was 1.443 (SD = 1.20). The marginal R^2, representing variance explained by fixed effects alone, was .013, while the conditional R^2, representing variance explained by both fixed and random effects, was .145. These values suggest that individual-level characteristics explained a small proportion of variance in physical abuse severity, though accounting for clustering by service substantially improved model fit, supporting the use of a multilevel approach.

Several individual-level characteristics were significantly associated with reported severity of physical abuse at intake. Age was a significant predictor. Compared to individuals aged 36–50, victim/survivors aged 19–35 reported higher levels of physical abuse (β = 0.19, 95% CI [0.16, 0.22], $p < .001$), as did those under the age of 18 (β = 0.28, 95% CI [0.19, 0.37], $p < .001$). In contrast, individuals aged 51 and older reported significantly lower levels of physical abuse (β = -0.06, 95% CI [-0.11, -0.01], $p = .012$).

Ethnicity was also a significant predictor for some groups. Compared to White victim/survivors, those identifying as Asian or Asian British (β = -0.11, 95% CI [-0.17, -0.05], $p < .001$) and Black, African, Caribbean, or Black British (β = -0.11, 95% CI [-0.21, -0.003], $p = .044$) reported lower levels of physical abuse. Ethnicity was not a significant predictor for those identifying as Mixed or multiple ethnic groups ($p = .994$) or from another ethnic group ($p = .165$).

Sexual orientation was significantly associated with physical abuse severity for one group. Victim/survivors identifying as gay reported higher levels of physical abuse compared to heterosexual individuals (β = 0.31, 95% CI [0.09, 0.52], $p = .006$). There were no significant differences for those identifying as bisexual ($p = .752$) or lesbian ($p = .135$).

Gender ($p = .587$) and disability ($p = .326$) status were not significantly associated with reported levels of physical abuse.

Finally, year of case opening (centred around 2020) was negatively associated with reported levels of physical abuse at intake (β = -0.05, 95% CI [-0.054, -0.037], $p < .001$), suggesting that more recent cases were associated with slightly lower reported severity of physical abuse.

Interaction Effects

Interaction effects that were found to significantly influence the levels of physical abuse recorded at intake are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Ethnicity and disability
- Age and ethnicity

Age and Sexuality

A significant interaction between age and sexual orientation indicated that bisexual women aged 19–35 reported significantly *lower* levels of physical abuse severity at intake than would be expected based on the independent effects of age and sexual orientation alone (β = −0.47, 95% CI [−0.74, −0.20], $p < .001$). Predicted values show this compounding effect (see Graph 14). Among bisexual women aged 19–35, the predicted abuse severity score was 2.37 (95% CI: 2.14, 2.60), compared to 2.55 among heterosexual women of the same age.

Another significant interaction was seen for women aged 51 and over who identified as gay (however, the numbers are low). Those aged 51+ who identified as gay reported significantly *higher* abuse severity than would be expected based on the independent effects of age and sexual orientation alone (β = 1.94, 95% CI [0.14, 3.74], $p = .035$). Predicted values illustrate this effect: among gay women aged 51+, the predicted abuse score was 3.39 (95% CI: 2.02, 4.76), compared to 2.26 among heterosexual women in the same age group. However, these findings should be interpreted with caution due to the very small number of clients aged 51 and over who identify as gay (n = 3).

A further significant interaction was observed for lesbian women aged 18 and under, who reported substantially lower abuse severity than would be expected based on the additive effects of age and sexual orientation (β = −0.98, 95% CI [−1.92, −0.04], $p = .041$). Among lesbian victim/survivors in this age group, the predicted abuse score was 1.90 (95% CI: 0.99, 2.81), in contrast to 2.62 among heterosexual victim/survivors. However, these findings should be interpreted with caution due to the very small number of clients aged 18 and under who identify as lesbian (n = 7).

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	2.62 (2.42, 2.83) n = 669	2.91 (2.43, 3.39) n = 28	n = 0	n = 7*
19–35	2.55 (2.37, 2.73) n = 15691	2.37 (2.14, 2.60) n = 275	2.69 (1.92, 3.45) n = 10	2.62 (2.34, 2.91) n = 113
35–50	2.34 (2.16, 2.52) n = 9365	2.63 (2.35, 2.92) n = 117	n = 6*	2.60 (2.27, 2.94) n = 71
51+	2.26 (2.07, 2.44) n = 2865	2.22 (1.56, 2.87) n = 14	n = 3*	2.43 (1.75, 3.11) n = 15

Table 11: *Predicted Level of Physical Abuse Reported at Intake by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.013 before adding in the fixed effects, indicating that approximately 1.3% of the variance in the severity of physical abuse was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in the level of physical abuse reported at intake across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.129, suggesting that 12.9% of the variance in severity of physical abuse at intake was attributable to differences between service providers.

Change in Physical Abuse from Intake to Exit

Change in physical abuse was calculated by subtracting the level of abuse at case exit from that at case intake. A higher positive value indicates a greater reduction in abuse, a value of zero indicates no change in the level of abuse, and a negative value indicates an increase in abuse.

There was modest between-service variability in abuse change scores, with an intraclass correlation coefficient (ICC) of .109, indicating that 10.9% of the variance in physical abuse change was attributable to differences between services. The random intercept variance was 0.20 (SD = 0.45), and the residual variance was 1.66 (SD = 1.29). The marginal R^2 (variance explained by fixed effects) was .008, and the conditional R^2 (variance explained by fixed and random effects) was .113. These results indicate that individual-level characteristics accounted for a small proportion of variation in change in physical abuse, although accounting for service-level clustering provided a better model fit.

Among the fixed effects, age was a significant predictor. Compared to individuals aged 36–50 (reference category), those aged 19–35 reported significantly greater reductions in physical abuse (β = 0.16, *SE* = 0.02, 95% CI [0.12, 0.20], $p < .001$), as did those under 18 (β = 0.24, *SE* = 0.06, 95% CI [0.12, 0.37], $p < .001$). The difference for those aged 51 and older was not statistically significant ($p = .215$).

Ethnicity was also a significant predictor in one group: individuals identifying with an "Other ethnic group" reported greater reductions in abuse compared to White participants (β = 0.26, *SE* = 0.10, 95% CI [0.06, 0.45], $p = .009$). No statistically significant differences were found for individuals identifying as Asian/Asian British ($p = .296$), Black/African/Caribbean/Black British ($p = .290$), or Mixed/multiple ethnic groups ($p = .622$).

There were no statistically significant effects of gender, disability status, or sexual orientation on changes in physical abuse from intake to exit. Male victim/survivors did not differ significantly from female victim/survivors in their change scores ($p = .783$). Similarly, those with a disability did not show significantly different changes in abuse compared to those without a disability ($p = .104$). Sexual orientation was also not a significant predictor: individuals identifying as bisexual ($p = .334$), gay ($p = .273$), or lesbian ($p = .803$) did not significantly differ from heterosexual individuals in their change in physical abuse.

Year of case opening was negatively associated with abuse reduction, indicating that more recent referrals (closer to 2020) were associated with slightly smaller reductions in abuse (β = -0.03, *SE* = 0.006, 95% CI [-0.046, -0.022], $p < .001$).

Interaction Effects

Interaction effects that were found to significantly influence the change in levels of physical abuse experienced from intake to exit are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality
- Ethnicity and disability

Age and Ethnicity

A significant interaction between age and ethnicity indicated that reductions in physical abuse from intake to exit varied across ethnic groups. Specifically, young women aged 18 and under from “Other” ethnic backgrounds reported significantly lower reductions in abuse than would be expected based on the independent effects of age and ethnicity alone (β = −1.33, 95% CI [−2.64, −0.02], $p = .046$).

Predicted values further illustrate this compounding effect. Among women aged 36–50, those from “Other” ethnic backgrounds showed some of the highest average reductions in abuse, with a predicted change score of 1.37 (95% CI: 1.03, 1.72), slightly higher than White women in the same age group (1.07, 95% CI: 0.89, 1.24). In contrast, among women aged 18 and under, those from “Other” ethnic backgrounds showed substantially smaller improvements, with a predicted change score of just 0.27 (95% CI: −1.00, 1.55), compared to 1.30 (95% CI: 1.08, 1.52) for their White peers. This interaction suggests a particular disadvantage for young victim/survivors from “Other” ethnic backgrounds in terms of experiencing reductions in physical abuse during support. These findings should be interpreted with caution due to the very small number of clients aged 18 and under reporting “Other” ethnicity (n = 6).

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	1.30 (1.08, 1.52) n = 628	1.43 (0.85, 2.01) n = 42	n = 6*	1.68 (0.98, 2.38) n = 23	n = 6*
19–35	1.22 (1.05, 1.40) n = 14486	1.18 (0.97, 1.38) n = 900	1.26 (0.99, 1.52) n = 267	1.27 (1.03, 1.52) n = 321	1.42 (1.10, 1.75) n = 130
36–50	1.07 (0.89, 1.24) n = 8307	1.04 (0.84, 1.25) n = 766	0.81 (0.55, 1.08) n = 241	0.97 (0.66, 1.28) n = 151	1.37 (1.03, 1.72) n = 106
51+	1.00 (0.82, 1.19) n = 2687	0.94 (0.63, 1.25) n = 142	1.00 (0.47, 1.54) n = 35	0.69 (-0.18, 1.55) n = 17	1.53 (0.74, 2.31) n = 17

Table 12: *Predicted Change in Physical Abuse by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Age and Sexuality

A significant interaction between age and sexual orientation was observed in relation to changes in physical abuse severity from intake to case exit for clients. Specifically, women aged 19-35 from who identified as bisexual showed significantly smaller reduction in physical abuse from intake to exit than would be expected based on the independent effects of age and sexuality alone (β = −0.37, 95% CI [−0.74, −0.005], p = .047).

Predicted values show this compounding effect. Among bisexual women aged 19–35, the predicted change in physical abuse was 1.01 (95% CI: 0.76, 1.27), compared to 1.23 (95% CI: 1.05, 1.40) among heterosexual women of the same age.

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	1.31 (1.09, 1.52) n = 669	1.57 (0.93, 2.21) n = 28	n = 0	n = 7*
19–35	1.23 (1.05, 1.40) n = 15691	1.01 (0.76, 1.27) n = 275	1.65 (0.60, 2.69) n = 10	1.20 (0.83, 1.56) n = 113
35–50	1.06 (0.88, 1.23) n = 9365	1.21 (0.86, 1.57) n = 117	n = 6*	1.36 (0.89, 1.82) n = 71
51+	1.00 (0.82, 1.18) n = 2865	1.06 (0.28, 1.84) n = 14	n = 3*	0.88 (0.02, 1.74) n = 15

Table 13: *Predicted Change in Physical Abuse by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.008 before adding in the fixed effects, indicating that approximately 0.8% of the variance in the change in level of physical abuse was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to near 0, which suggests that there were negligible systematic differences in the change in physical abuse reported across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.102, suggesting that 10.2% of the variance in change in physical abuse from intake to exit was attributable to differences between service providers.

Level of Sexual Abuse at Intake

Sexual abuse severity recorded at intake was measured on a 4-point ordinal scale (1 = no sexual abuse, 2 = standard level, 3 = moderate level, 4 = high level), with higher scores indicating greater severity. There was minimal variability in sexual abuse levels across services. The intraclass correlation coefficient (ICC) was .095, indicating that approximately 9.5% of the variance in the level of sexual abuse recorded at intake was attributable to differences between service providers. The random intercept variance was 0.076 (SD = 0.28), and the residual variance was 0.903 (SD = 0.95). The marginal R^2, representing variance explained by fixed effects alone, was .012, while the conditional R^2, representing variance explained by both fixed and random effects, was .089. These values suggest that individual-level characteristics explained a small proportion of variance in the level of sexual abuse recorded at intake, and accounting for clustering by service provider modestly improved model fit.

Several individual-level characteristics were significantly associated with the level of sexual abuse recorded at intake.

Gender was a significant predictor: male victim/survivors had significantly lower levels of sexual abuse recorded at intake compared to female victim/survivors (β = -0.26, 95% CI [-0.31, -0.20], $p < .001$). Age was also significantly associated with this outcome. Compared to those aged 36–50 (reference group), individuals aged 19–35 had slightly higher levels recorded (β = 0.03, 95% CI [0.004, 0.053], $p = .022$), as did those under 18 (β = 0.23, 95% CI [0.15, 0.30], $p < .001$). In contrast, those aged 51 and older had significantly lower levels recorded (β = -0.18, 95% CI [-0.22, -0.14], $p < .001$).

Ethnicity was also associated with the level of sexual abuse recorded at intake. Compared to White victim/survivors, those identifying as Asian or Asian British (β = 0.09, 95% CI [0.04, 0.14], $p < .001$), Black, African, Caribbean, or Black British (β = 0.13, 95% CI [0.05, 0.21], $p = .002$), and those from other ethnic groups (β = 0.19, 95% CI [0.07, 0.32], $p = .002$) had significantly higher levels recorded. No significant differences were found for those identifying as Mixed or multiple ethnic groups ($p = .522$).

Victim/survivors with a disability had significantly higher levels of sexual abuse recorded at intake compared to those without a disability (β = 0.14, 95% CI [0.11, 0.17], $p < .001$). Similarly, sexual orientation was a significant predictor for some groups: those identifying as bisexual (β = 0.14, 95% CI [0.05, 0.23], $p = .002$) or gay (β = 0.32, 95% CI [0.15, 0.50], $p < .001$) had significantly higher levels recorded than heterosexual victim/survivors. No significant difference was found for lesbian victim/survivors (p = .687).

The year the case was opened, centred around 2020, was not significantly associated with the level of sexual abuse recorded at intake ($p = .256$), suggesting that time trends were not a strong factor in this outcome.

Interaction Effects

Interaction effects that were found to significantly influence the levels of sexual abuse recorded at intake are listed below. The following interactions were not found to be significant:

- Age and sexuality

Ethnicity and Sexuality

A significant interaction between sexual orientation and ethnicity indicated that lesbian women from “Other” ethnic groups reported significantly higher levels of sexual abuse at intake than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = 1.57, 95% CI [0.45, 2.68], $p = .006$).

Predicted values show this compounding effect. Among heterosexual individuals from “other” ethnic groups the predicted abuse score was 1.72 (95% CI [1.56, 1.88]), slightly higher than White heterosexuals at 1.54 (95% CI [1.43, 1.65]). The numbers are low for comparisons to be made across some of the ethnic groups and sexualities.

Ethnicity and Disability

A significant interaction between ethnicity and disability status indicated that women from Mixed/multiple ethnic backgrounds who also reported a disability disclosed significantly lower levels of sexual abuse than would be expected based on the independent effects of ethnicity and disability alone (β = −0.25, 95% CI [−0.50, −0.01], $p = .042$).

Predicted values show this compounding effect. Among White women without a disability the predicted abuse score was 1.54 (95% CI [1.43, 1.65]), slightly higher than Women from Mixed/multiple ethnic backgrounds without a disability at 1.54 (95% CI [1.40, 1.68]). However, among women from Mixed/multiple ethnic groups with a disability, the predicted score decreased to 1.44 (95% CI [1.19, 1.69]), in contrast to 1.69 among women without a disability in the same ethnic group (95% CI [1.58, 1.81]).

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	1.54 (1.43, 1.65) n = 22239	1.64 (1.52, 1.76) n = 1588	1.69 (1.55, 1.83) n = 469	1.54 (1.40, 1.68) n = 429	1.73 (1.56, 1.91) n = 220
Yes	1.69 (1.58, 1.81) n = 3869	1.71 (1.55, 1.87) n = 262	1.68 (1.43, 1.92) n = 80	1.44 (1.19, 1.69) n = 83	1.93 (1.60, 2.26) n = 39

Table 14: *Predicted Level of Sexual Abuse at Intake by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Ethnicity

A significant interaction between age and ethnicity indicated that the relationship between age and sexual abuse severity at intake varied across ethnic groups. Specifically, young women (18 and under) from an "Other" ethnic group reported significantly lower levels of sexual abuse severity than would be expected based on the independent effects of age and ethnicity alone (β = −1.03, 95% CI [−1.83, −0.23], p = .011). Similarly, among Asian / Asian British women, those aged 18 and under reported significantly lower levels of abuse severity than would be anticipated from the additive effects of age and ethnicity (β = −0.75, 95% CI [−1.08, −0.42], p < .001). In contrast, a significant positive interaction was found between being aged 19–35 and identifying as Black / African / Caribbean / Black British, such that women in this group reported higher levels of abuse severity than expected from the individual effects of age and ethnicity (β = 0.32, 95% CI [0.15, 0.50], p < .001).

Predicted values further illustrate these interaction effects. Among women aged 18 and under, those from an "Other" ethnic group had a markedly lower predicted severity score of 0.90 (95% CI [0.12, 1.68]) compared to 1.83 (95% CI [1.70, 1.96]) among White victim/survivors. However, this interaction should be interpreted with caution due to the very small number of women aged 18 and under from "Other" ethnic groups (n = 6). A similar trend was observed for Asian / Asian British women, where those aged 18 and under had a predicted score of 1.16 (95% CI [0.84, 1.49]) compared to 1.83 for their White counterparts.

Conversely, among Black / African / Caribbean / Black British women aged 19–35, the predicted severity score was notably higher at 1.85 (95% CI [1.70, 2.01]) than the score for White women in the same age group (1.56, 95% CI [1.45, 1.67]).

These findings suggest complex intersectional patterns in how age and ethnicity combine to influence the severity of sexual abuse experiences reported at intake

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	1.83 (1.70, 1.96) n = 628	1.16 (0.84, 1.49) n = 42	n = 6*	1.89 (1.47, 2.32) n = 23	n = 6*
19–35	1.56 (1.45, 1.67) n = 14486	1.71 (1.58, 1.83) n = 900	1.85 (1.70, 2.01) n = 267	1.53 (1.38, 1.68) n = 321	1.88 (1.68, 2.09) n = 130
36–50	1.54 (1.44, 1.65) n = 8307	1.63 (1.50, 1.75) n = 766	1.52 (1.35, 1.68) n = 241	1.47 (1.28, 1.67) n = 151	1.65 (1.43, 1.87) n = 106

51+	1.35 (1.24, 1.47) n = 2687	1.38 (1.19, 1.57) n = 142	1.28 (0.93, 1.63) n = 35	1.37 (0.89, 1.86) n = 17	1.65 (1.17, 2.13) n = 17

Table 15: *Predicted Level of Sexual Abuse at Intake by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low and is therefore not represented within the corresponding graph.*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.04 before adding in the fixed effects, indicating that approximately 4.0% of the variance in level of sexual abuse at intake was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0.002. This suggests that 0.2% of the variance in level of sexual abuse experienced at intake remained attributable to between group differences, with most of the variance explained by individual identity characteristics. The ICC for service-provider was 0.076, suggesting that 7.6% of the variance in severity of sexual abuse at intake was attributable to differences between service providers.

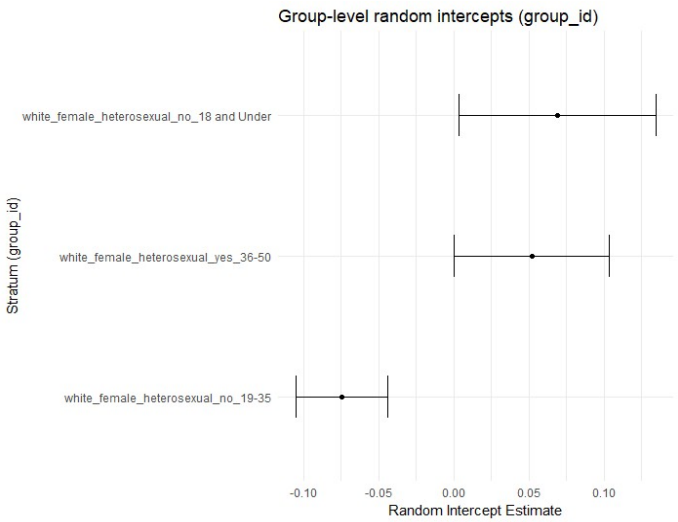
Two identity strata were found to have random intercepts significantly greater than zero, indicating that individuals in these groups had significantly higher levels of sexual abuse at intake than predicted by the fixed effects alone. This included:

- **White, heterosexual females aged 18 and under without a disability** – the estimated random intercept for this stratum was 0.07 (*SE* = 0.03,95% CI: 0.003 to 0.13) suggesting that members of this group exhibited, on average, sexual abuse scores at intake that were 0.07 units higher than the predicted value of 1.73 based on the fixed effects alone (n = 551).

- **White, heterosexual females aged 36-50 with a disability** – the estimated random intercept for this stratum was 0.05 (*SE* = 0.03,95% CI: 0.0002 to 0.10) suggesting that members of this group exhibited, on average, sexual abuse scores at intake that were 0.05 units higher than the predicted value of 1.65 based on the fixed effects alone (n = 1,258).

One identity strata was found to have random intercepts significantly lower than zero, indicating that individuals in this group had significantly lower levels of sexual abuse at intake than predicted by the fixed effects alone. This included:

- **White, heterosexual females aged 19 to 35 without a disability** – the estimated random intercept for this stratum was -0.07 (*SE* = 0.02,95% CI: -0.11 to -0.04) suggesting that members of this group exhibited, on average, sexual abuse scores at intake that were 0.07 units lower than the predicted value of 1.63 based on the fixed effects alone (n = 12,579).



Graph 7: *The estimated random intercept for sexual abuse at intake for white, heterosexual females, separated by age group. The age group 19-35 had random intercepts significantly lower than zero, indicating that individuals in this group had significantly lower levels of sexual abuse at intake than predicted by the fixed effects alone.*

Change in Sexual Abuse from Intake to Exit

Change in sexual abuse was calculated by subtracting the level of sexual abuse at case exit from that at case intake, such that a higher positive value indicates a greater reduction in abuse, a value of zero indicates no change in the level of abuse, and a negative value indicates an increase in abuse. There was minimal between-service variability in abuse change scores, with an intraclass correlation coefficient (ICC) of .079, indicating that 7.9% of the variance in change in sexual abuse was attributable to differences between services. The random intercept variance was 0.058 (SD = 0.24), and the residual variance was 0.883 (SD = 0.94). The marginal R^2 (variance explained by fixed effects) was .008, and the conditional R^2 (variance explained by fixed and random effects) was .069. These results indicate that individual-level characteristics accounted for a small proportion of variation in change in sexual abuse, although accounting for service-level clustering modestly improved model fit.

Several individual-level characteristics were significantly associated with change in sexual abuse. Gender was a significant predictor: male victim/survivors experienced significantly smaller reductions in sexual abuse compared to female victim/survivors (β = -0.22, SE = 0.03, 95% CI [-0.28, -0.15], p < .001).

Age was also associated with changes in sexual abuse. Compared to individuals aged 36–50 (reference group), those aged under 18 reported significantly greater reductions in sexual abuse (β = 0.13, SE = 0.05, 95% CI [0.03, 0.22], p = .007). Conversely, individuals aged 51 and older reported significantly smaller reductions (β = -0.15, SE = 0.02, 95% CI [-0.20, -0.10], p < .001). There were no significant differences for those aged 19–35 years old (p = .050)

Ethnicity was also a significant predictor. Compared to White victim/survivors, those identifying as Asian or Asian British (β = 0.11, SE = 0.03, 95% CI [0.06, 0.17], p < .001), Black, African, Caribbean, or Black British (β = 0.14, SE = 0.05, 95% CI [0.04, 0.24], p = .007), and from Other ethnic groups (β = 0.23, SE = 0.07, 95% CI [0.09, 0.38], p = .002) experienced significantly greater reductions in sexual abuse. There were no significant differences for those identifying as Mixed or multiple ethnic groups (p = .740).

Disability status was also significantly associated with change in sexual abuse: victim/survivors with a disability experienced significantly greater reductions in levels of sexual abuse from intake to exit than those without a disability (β = 0.08, SE = 0.02, 95% CI [0.04, 0.12], p < .001).

Among sexual orientation groups, individuals identifying as gay experienced significantly greater reductions in sexual abuse compared to heterosexual individuals (β = 0.26, SE = 0.11, 95% CI [0.04, 0.47], p = .022). There were no significant differences for individuals identifying as bisexual (p = .942) or lesbian (p = .900).

The year the case was opened, centred around 2020, was not significantly associated with changes in sexual abuse (p = .831), suggesting that time trends did not have a notable effect on this outcome.

Interaction Effects

Interaction effects that were found to significantly influence the change in levels of sexual abuse experienced from intake to exit are listed below. The following interactions were not found to be significant:

- Age and sexuality

Ethnicity and Sexuality

A significant interaction between sexual orientation and ethnicity indicated that bisexual women from Black / African / Caribbean / Black British ethnic groups reported significantly higher reduction in sexual abuse from intake to exit than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = 0.98, 95% CI [0.27, 1.68], p = .006). Similarly, lesbian women from “Other” ethnic groups reported significantly higher reduction in sexual abuse from intake to exit than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = 2.24, 95% CI [0.35, 4.12], p = .020)

Predicted values show this compounding effect. Among heterosexual individuals from Black / African / Caribbean / Black British ethnic groups the predicted abuse score was 0.55 (95% CI [0.42, 0.68]), slightly higher than White heterosexuals at 0.42 (95% CI [0.33, 0.51]). However, among bisexual women in this ethnic group, the predicted change in level of sexual abuse increased to 1.47 (95% CI:

0.79, 2.15), in contrast to 0.55 among heterosexual women of the same ethnic group. However, these findings should be interpreted with caution due to the small number of victim/survivors who identified as bisexual from Black / African / Caribbean / Black British ethnic groups (n = 18). There are also low numbers in non-white ethnic groups for Gay and Lesbian victim/survivors.

Sexuality	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
Heterosexual	0.42 (0.33, 0.51) n = 25505	0.54 (0.43, 0.64) n = 1817	0.55 (0.42, 0.68) n = 526	0.43 (0.29, 0.57) n = 493	0.67 (0.49, 0.84) n = 249
Bisexual	0.37 (0.22, 0.52) n = 377	0.93 (0.35, 1.50) n = 23	1.47 (0.79, 2.15) n = 18	0.50 (-0.34, 1.35) n = 13	n = 3*
Gay	0.24 (-0.43, 0.90) n = 19	n = 0	n = 0	n = 0	n = 0
Lesbian	0.44 (0.23, 0.64) n = 193	n = 6*	n = 2*	n = 2*	n = 3*

Table 16: *Predicted Change in Level of Sexual Abuse by Ethnicity and Sexuality. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Ethnicity and Disability

A significant interaction between ethnicity and disability status indicated that women from Mixed/multiple ethnic backgrounds who also reported a disability disclosed significantly lower reduction in sexual abuse from intake to exit than would be expected based on the independent effects of ethnicity and disability alone (β = −0.35, 95% CI [−0.64, −0.06], p = .002). A similar pattern is also seen in disabled women from Asian / Asian British backgrounds showing a significantly lower reduction in sexual abuse from intake to exit than would be expected based on the independent effects of ethnicity and disability alone (β = −0.16, 95% CI [−0.33, −0.001], p = .048).

Predicted values show this compounding effect. Among White women without a disability the predicted abuse score was 0.43 (95% CI [0.33, 0.52]), slightly lower than Women from Mixed/multiple ethnic backgrounds without a disability at 0.49 (95% CI [0.32, 0.67]) and Asian / Asian British backgrounds at 0.59 (95% CI [0.44, 0.73]). However, among women from Mixed/multiple ethnic groups with a disability, the predicted score decreased to 0.24 (95% CI [-0.04, 0.52]), in contrast to 0.49 among women without a disability in the same ethnic group. Among women from Asian / Asian British ethnic groups with a disability this decreased to 0.50 (95% CI 0.32, 0.67]), compared to 0.59 among women without a disability in the same ethnic group.

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	0.43 (0.33, 0.52) n = 22239	0.56 (0.45, 0.68) n = 1588	0.59 (0.44, 0.73) n = 469	0.49 (0.34, 0.64) n = 429	0.64 (0.46, 0.83) n = 220
Yes	0.52 (0.42, 0.63) n = 3869	0.50 (0.32, 0.67) n = 262	0.58 (0.29, 0.87) n = 80	0.24 (-0.04, 0.52) n = 83	1.00 (0.54, 1.46) n = 39

Table 17: *Predicted Change in Level of Sexual Abuse by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Ethnicity

A significant interaction between age and ethnicity indicated that the relationship between age and sexual abuse severity at intake varied across ethnic groups. Specifically, young women (18 and under) from an Asian / Asian British ethnic group reported significantly lower reduction in sexual abuse from intake to exit than would be expected based on the independent effects of age and ethnicity alone (β = −0.50, 95% CI [−0.93, −0.07], p = .022). In contract, among Black / African / Caribbean / Black British women, those aged 18 and under reported significantly higher reduction in sexual abuse from intake to exit than would be anticipated from the additive effects of age and ethnicity (β = 1.37, 95% CI [0.28, 2.47], p < .014). Additionally, a significant positive interaction was also found between being aged 19–

35 and identifying as Black / African / Caribbean / Black British, such that women in this group experienced significantly higher reduction in sexual abuse from intake to exit than expected from the individual effects of age and ethnicity (β = 0.30, 95% CI [0.08, 0.51], $p < .007$).

Predicted values further illustrate these interaction effects. Among women aged 18 and under, those from Asian / Asian British backgrounds had a markedly lower predicted score for reduction in sexual abuse from intake to exit of 0.19 (95% CI [-0.23, 0.61]) compared to 0.58 (95% CI [0.44, 0.72]) among White victim/survivors in the same age group.

Among Black / African / Caribbean / Black British women aged 19-35 and under, the predicted reduction in sexual abuse from intake to exit score was 0.74 (95% CI [0.56, 0.91]), higher than the score for White women in the same age group (0.45 (95% CI [0.36, 0.55]).

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	0.58 (0.44, 0.72) n = 628	0.19 (-0.23, 0.61) n = 42	n = 6*	0.82 (0.27, 1.37) n = 23	n = 6*
19–35	0.45 (0.36, 0.55) n = 14486	0.60 (0.47, 0.72) n = 900	0.74 (0.56, 0.91) n = 267	0.48 (0.32, 0.65) n = 321	0.75 (0.52, 0.98) n = 130
36–50	0.43 (0.34, 0.53) n = 8307	0.54 (0.42, 0.67) n = 766	0.42 (0.24, 0.60) n = 241	0.33 (0.11, 0.55) n = 151	0.64 (0.39, 0.89) n = 106
51+	0.27 (0.16, 0.38) n = 2687	0.39 (0.18, 0.60) n = 142	0.34 (-0.05, 0.73) n = 35	0.60 (-0.07, 1.27) n = 17	0.74 (0.14, 1.34) n = 17

Table 18: *Predicted Change in Level of Sexual Abuse by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.008 before adding in the fixed effects**,** indicating that approximately 0.8% of the variance in change in level of sexual abuse from intake to exit was attributable to differences between identity strata. After including the fixed effects, therefore**,** adjusting for individual identity characteristics, the ICC for identity strata decreased to effectively zero (9.1×10^{-17}). This suggests that observed differences between identity strata were mainly accounted for by individual-level identity factors, with little remaining unexplained group-level variance. The ICC for service-provider was 0.102, suggesting that 10.2% of the variance in change in level of sexual abuse from intake to exit was attributable to differences between service providers.

One identity strata was found to have random intercepts significantly lower than zero, indicating that individuals in this groups experienced significantly lower reductions in sexual abuse from intake to exit than predicted by the fixed effects alone. This included:

> **White, heterosexual females aged 19-35 without a disability** – the estimated random intercept for this stratum was -0.04 (*SE* = 0.02, 95% CI: -0.07 to -0.01) suggesting that members of this group experienced, on average, a lower predicted score for reduction in sexual abuse from intake to exit of 0.04. This was lower than the predicted value of 1.63 base on the fixed effects alone (n = 12,579).

Level of Harassment and Stalking at Intake

Harassment and stalking severity was measured on a 4-point ordinal scale (1 = no harassment/stalking, 2 = standard level, 3 = moderate level, 4 = high level), with higher scores indicating greater severity. There was moderate variability in harassment and stalking levels across services. The intraclass correlation coefficient (ICC) was .118, indicating that approximately 11.8% of the variance in the level of harassment and stalking recorded at intake was attributable to differences between service providers. The random intercept variance was 0.185 (SD = 0.43), and the residual variance was 1.356 (SD = 1.16). The marginal R^2, representing variance explained by fixed effects alone, was .019, while the conditional R^2, representing variance explained by both fixed and random effects, was .137. These values suggest that individual-level characteristics explained a small proportion of variance in the level

of harassment and stalking recorded at intake, and accounting for clustering by service provider substantially improved model fit.

Several individual-level characteristics were significantly associated with the level of harassment and stalking recorded at intake. Gender was a significant predictor: male victim/survivors had significantly lower levels of harassment and stalking recorded at intake compared to female victim/survivors (β = -0.23, 95% CI [-0.29, -0.16], $p < .001$). Age was also significantly related with this outcome. Compared to those aged 36–50 (reference group), individuals aged 19–35 had higher levels recorded (β = 0.09, 95% CI [0.06, 0.12], $p < .001$), while those aged 51 and older had significantly lower levels recorded (β = -0.27, 95% CI [-0.32, -0.22], $p < .001$). No significant differences were found for those under 18 ($p = .236$).

Ethnicity was also significantly associated with levels of harassment and stalking. Compared to White victim/survivors, those identifying as Asian or Asian British (β = -0.37, 95% CI [-0.43, -0.31], $p < .001$), Black, African, Caribbean, or Black British (β = -0.40, 95% CI [-0.50, -0.29], $p < .001$), Mixed or multiple ethnic groups (β = -0.12, 95% CI [-0.23, -0.02], $p = .020$), and Other ethnic groups (β = -0.24, 95% CI [-0.39, -0.09], $p = .001$) had significantly lower levels of harassment and stalking recorded at intake.

Having a disability was not significantly associated with this outcome ($p = .108$). Similarly, sexual orientation was not a significant predictor for bisexual ($p = .332$), gay ($p = .362$), or lesbian ($p = .094$) victim/survivors.

The year the case was opened, centred around 2020, was significantly associated with the level of harassment and stalking recorded at intake. More recent cases had slightly lower levels recorded (β = -0.03, 95% CI [-0.034, -0.017], $p < .001$), suggesting a modest time-related decrease in this outcome.

Interaction Effects

Interaction effects that were found to significantly influence the levels of harassment and stalking recorded at intake are listed below. The following interactions were not found to be significant:

- Ethnicity and sexuality

Ethnicity and Disability

A significant interaction between ethnicity and disability status indicated that women from Asian / Asian British backgrounds who also reported a disability disclosed significantly higher levels of harassment and stalking than would be expected based on the independent effects of ethnicity and disability alone (β = 0.17, 95% CI [0.00, 0.33], $p = .048$). A second significant interaction was found for women from Other ethnic groups with disabilities, who also reported higher levels of harassment/stalking than expected based on the independent effects of ethnicity and disability alone (β = 0.41, 95% CI [0.00, 0.82], $p = .050$).

Among Asian / Asian British women, the predicted level of harassment/stalking at intake increased from 1.89 (95% CI [1.72, 2.07]) for those without a disability to 2.01 (95% CI [1.79, 2.23]) for those with a disability. Similarly, among women from Other ethnic groups, the predicted score increased from 2.02 (95% CI [1.79, 2.25]) to 2.38 (95% CI [1.97, 2.80]) when disability was reported. These findings highlight a compounding effect for certain ethnic minority women with disabilities, who disclosed higher levels of harassment and stalking than would be anticipated based on either factor alone.

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	2.30 (2.14, 2.46) n = 22239	1.89 (1.72, 2.07) n = 1588	1.87 (1.68, 2.07) n = 469	2.15 (1.95, 2.34) n = 429	2.02 (1.79, 2.25) n = 220
Yes	2.25 (2.09, 2.42) n = 3869	2.01 (1.79, 2.23) n = 262	1.97 (1.66, 2.28) n = 80	2.12 (1.82, 2.43) n = 83	2.38 (1.97, 2.80) n = 39

Table 19: *Predicted Level of Harassment and Stalking at Intake by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Ethnicity

A significant interaction between age and ethnicity indicated that the relationship between age and harassment/stalking severity at intake varied across ethnic groups. Specifically, older women (aged 51 and older) from Asian / Asian British backgrounds reported significantly *higher* levels of harassment/stalking than would be expected based on the independent effects of age and ethnicity alone (β = 0.24, 95% CI [0.03, 0.46], p = .028). Similarly, older women (aged 51 and older) from "Other ethnic" backgrounds reported significantly *higher* levels of harassment/stalking than would be expected based on the independent effects of age and ethnicity alone (β = 0.74, 95% CI [0.14, 1.35], p = .015).

Predicted values further illustrate these interaction effects. Asian / Asian British women aged 51 and over, had a predicted harassment and stalking score of 1.90 (95% CI [1.64, 2.15]), which is lower than that of White women in the same age group, yet higher than expected based on the additive main effects of age and ethnicity alone. This suggests a positive interaction effect, where the reduction in predicted severity typically associated with being both older and Asian is somewhat attenuated for this group.

These findings highlight intersectional vulnerabilities among older ethnic minority women, suggesting that age may amplify the experiences of harassment and stalking for some groups, particularly those from Asian and Other ethnic backgrounds.

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	2.36 (2.17, 2.55) n = 628	1.92 (1.51, 2.32) n = 42	n = 6*	2.20 (1.69, 2.72) n = 23	n = 6*
19–35	2.41 (2.25, 2.57) n = 14486	1.95 (1.77, 2.13) n = 900	1.99 (1.77, 2.21) n = 267	2.22 (2.01, 2.43) n = 321	2.05 (1.79, 2.32) n = 130
36–50	2.30 (2.14, 2.47) n = 8307	1.95 (1.77, 2.13) n = 766	1.90 (1.68, 2.12) n = 241	2.20 (1.95, 2.45) n = 151	2.09 (1.81, 2.37) n = 106
51+	2.00 (1.83, 2.17) n = 2687	1.90 (1.64, 2.15) n = 142	1.53 (1.09, 1.96) n = 35	2.06 (1.46, 2.65) n = 17	2.53 (1.95, 3.11) n = 17

Table 20: *Predicted Level of Harassment and Stalking at Intake by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Age and Sexuality

A significant interaction between age and sexual orientation indicated that bisexual women aged 18 and under reported significantly higher levels of harassment/stalking severity at intake than would be expected based on the independent effects of age and sexual orientation alone (β = 0.60, 95% CI [0.11, 1.10], p = .017). Predicted values show this compounding effect, among bisexual women aged 18 and under, the predicted severity score was 3.11 (95% CI: 2.65, 3.57), compared to 2.33 (95% CI: 2.14, 2.46) among heterosexual women of the same age.

Age	Heterosexual	Bisexual	Gay	Lesbian
18 and under	2.33 (2.14, 2.52) n = 669	3.11 (2.65, 3.57) n = 28	n = 0	n = 7*
19–35	2.40 (2.24, 2.57) n = 15691	2.32 (2.10, 2.53) n = 275	2.79 (1.97, 3.62) n = 10	2.40 (2.13, 2.67) n = 113
35–50	2.30 (2.14, 2.46) n = 9365	2.48 (2.20, 2.75) n = 117	n = 6*	2.63 (2.31, 2.95) n = 71
51+	2.02 (1.85, 2.19) n = 2865	2.12 (1.49, 2.75) n = 14	n = 3*	2.30 (1.66, 2.93) n = 15

Table 21: *Predicted Level of Harassment and Stalking at Intake by Sexual Orientation and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis

The ICC for the identity strata was 0.024, suggesting that 2.4% of the variance in level of harassment and stalking experience at intake was attributable to differences between identity strata.

The intraclass correlation coefficient (ICC) for the identity strata was 0.024 before adding in the fixed effects**,** indicating that approximately 2.4% of the variance in level of harassment and stalking reported at intake was attributable to differences between identity strata. After including the fixed effects, therefore**,** adjusting for individual identity characteristics, the ICC for identity strata decreased to 0.002. This suggests that 0.2% of the variance in level of harassment and stalking reported at intake remained attributable to between group differences, with most of the variance explained by individual identity characteristics. The ICC for service-provider was 0.115, suggesting that 11.5% of the variance in in level of harassment and stalking reported at intake was attributable to differences between service providers.

Two identity strata were found to have random intercepts significantly greater than zero, indicating that individuals in these groups had significantly higher levels of harassment and stalking at intake than predicted by the fixed effects alone. This included:

- **White, heterosexual females aged 19-35 without a disability** – the estimated random intercept for this stratum was 0.11 (*SE* = 0.02,95% CI: 0.07 to 0.15) suggesting that members of this group exhibited, on average, harassment and stalking scores at intake that were 0.11 units higher than the predicted value of 2.30, based on the fixed effects alone (n = 12,579).
- **White, heterosexual females aged 19-35 with a disability** – the estimated random intercept for this stratum was 0.06 (*SE* = 0.03,95% CI: 0.001 to 0.12) suggesting that members of this group exhibited, on average, harassment and stalking scores at intake that were 0.06 units higher than the predicted value of 2.27, based on the fixed effects alone (n = 1,540).

One identity strata was found to have random intercepts significantly lower than zero, indicating that individuals in this group had significantly lower levels of harassment and stalking at intake than predicted by the fixed effects alone. This included:

- **White, heterosexual females aged 51 and over with a disability** – the estimated random intercept for this stratum was -0.10 (*SE* = 0.04,95% CI: -0.16 to -0.03) suggesting that members of this group exhibited, on average, harassment and stalking scores at intake that were 0.10 units lower than the predicted value of 2.03, based on the fixed effects alone (n = 858).

Change in Harassment and Stalking from Intake to Exit

Change in harassment and stalking was calculated by subtracting the level at case exit from that at intake. A higher positive value indicates a greater reduction in harassment and stalking, a value of zero indicates no change, and a negative value indicates an increase in harassment and stalking from intake to exit. There was modest between-service variability in harassment and stalking change scores. The intraclass correlation coefficient (ICC) was .069, indicating that 6.9% of the variance in change in harassment and stalking was attributable to differences between services. The random intercept variance was 0.110 (SD = 0.33), and the residual variance was 1.503 (SD = 1.23). The marginal R^2 (variance explained by fixed effects) was .011, and the conditional R^2 (variance explained by both fixed and random effects) was .078. These results suggest that individual-level characteristics accounted for a small proportion of the variation in change in harassment and stalking, though including service-level clustering modestly improved model fit.

Several individual-level characteristics were significantly associated with changes in harassment and stalking. Gender was a significant predictor with male victim/survivors experienced significantly smaller reductions in harassment and stalking than female victim/survivors (β = -0.19, SE = 0.04, 95% CI [-0.28, -0.10], $p < .001$).

Age was also significantly associated with this outcome. Compared to individuals aged 36–50 (reference group), those aged 19–35 experienced significantly greater reductions in harassment and stalking (β = 0.12, SE = 0.02, 95% CI [0.08, 0.16], $p < .001$), while those aged 51 and older experienced

significantly smaller reductions (β = -0.16, SE = 0.03, 95% CI [-0.22, -0.09], $p < .001$). There were no significant differences for those aged under 18 ($p = .186$).

Ethnicity was also a significant predictor. Compared to White victim/survivors, those identifying as Asian or Asian British (β = -0.27, SE = 0.04, 95% CI [-0.35, -0.20], $p < .001$), Black, African, Caribbean, or Black British (β = -0.26, SE = 0.07, 95% CI [-0.39, -0.13], $p < .001$), and those from Other ethnic groups (β = -0.24, SE = 0.10, 95% CI [-0.43, -0.05], $p = .013$) experienced significantly smaller reductions in harassment and stalking. There were no significant differences for those identifying as Mixed or multiple ethnic groups ($p = .258$).

Disability status was also associated with change in harassment and stalking. Victim/survivors with a disability experienced significantly smaller reductions compared to those without a disability (β = -0.06, SE = 0.03, 95% CI [-0.12, -0.01], $p = .013$).

Sexual orientation was not a significant predictor of change in harassment and stalking. There were no significant differences between heterosexual victim/survivors and those identifying as bisexual ($p = .289$), gay ($p = .788$), or lesbian ($p = .405$).

The year the case was opened, centred around 2020, was not significantly associated with changes in harassment and stalking ($p = .585$), indicating that time trends did not have a notable effect on this outcome.

Interaction Effects

Interaction effects that were found to significantly influence the change in levels of harassment and stalking experienced from intake to exit are listed below. The following interactions were not found to be significant:

- Age and sexuality

Ethnicity and Sexuality

A significant interaction between sexual orientation and ethnicity indicated that bisexual women from Black / African / Caribbean / Black British ethnic groups reported significantly higher reductions in harassment and stalking from intake to exit than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = 0.96, 95% CI [0.06, 1.86], $p = .037$).

Predicted values show this compounding effect. Among heterosexual individuals from Black / African / Caribbean / Black British ethnic groups the predicted change in harassment and stalking was 0.52 (95% CI [0.33, 0.71]), lower than White heterosexuals at 0.80 (95% CI [0.33, 0.51]). However, among bisexual women in this ethnic group, the predicted change in level of harassment and stalking increased to 1.51 (95% CI: 0.63, 2.39), in contrast to 0.52 among heterosexual women of the same ethnic group. However, these findings should be interpreted with caution due to the small number of victim/survivors who identified as bisexual from Black / African / Caribbean / Black British ethnic groups (n = 18).

Sexuality	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
Heterosexual	0.80 (0.67, 0.93) *n = 25505*	0.52 (0.37, 0.67) *n = 1817*	0.52 (0.33, 0.71) *n = 526*	0.69 (0.50, 0.88) *n = 493*	0.56 (0.33, 0.79) *n = 249*
Bisexual	0.83 (0.63, 1.04) *n = 377*	0.83 (0.11, 1.54) *n = 23*	1.51 (0.63, 2.39) *n = 18*	0.85 (-0.24, 1.95) *n = 13*	*n = 3**
Gay	1.08 (0.22, 1.95) *n = 19*	*n = 0*	*n = 0*	*n = 0*	*n = 0*
Lesbian	0.91 (0.63, 1.19) *n = 193*	*n = 6**	*n = 2**	*n = 2**	*n = 3**

Table 22: *Predicted Change in Harassment and Stalking by Ethnicity and Sexuality. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Ethnicity and Disability
A significant interaction between ethnicity and disability status indicated that women from "Other" ethnic backgrounds who also reported a disability disclosed significantly higher reduction in harassment and stalking from intake to exit than would be expected based on the independent effects of ethnicity and disability alone (β = 0.73, 95% CI [0.11, 1.36], *p* = .020).

Predicted values show this compounding effect. Among White women without a disability the predicted abuse score was 0.88 (95% CI [0.66, 0.94]), slightly higher than Women from "Other" ethnic backgrounds without a disability at 0.50 (95% CI [0.26, 0.74]). However, among women from "Other" ethnic groups with a disability, the predicted score increased to 1.14 (95% CI [0.54, 1.75]), in contrast to 0.50 among women without a disability in the same ethnic group.

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No	0.80 (0.66, 0.94) n = 22239	0.50 (0.35, 0.66) n = 1588	0.51 (0.32, 0.71) n = 469	0.66 (0.46, 0.86) n = 429	0.50 (0.26, 0.74) n = 220
Yes	0.71 (0.57, 0.86) n = 3869	0.55 (0.32, 0.78) n = 262	0.64 (0.26, 1.02) n = 80	0.75 (0.38, 1.11) n = 83	1.14 (0.54, 1.75) n = 39

Table 23: *Predicted Change in Harassment and Stalking by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.*

Age and Ethnicity
A significant interaction between age and ethnicity indicated that the relationship between age and change in levels of harassment and stalking from intake to exit varied across ethnic groups. Specifically, older women (51 and over) from an "Other" ethnic background reported a significantly higher reduction in level of harassment and stalking from intake to exit than would be expected based on the independent effects of age and ethnicity alone (β = 0.93, 95% CI [0.14, 1.71], *p* = .021).

Predicted values further illustrate this interaction effect. Among women 51 and under, those from "Other" ethnic backgrounds had a markedly higher predicted score for reduction in harassment and stalking from intake to exit of 1.18 (95% CI [0.44, 1.92]) compared to 0.61 (95% CI [0.46, 0.75]) among White victim/survivors in the same age group. However, these findings should be interpreted with caution due to the small number of victim/survivors from "Other" ethnic backgrounds aged 51 and over (n = 17).

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	0.88 (0.70, 1.06) n = 628	0.59 (0.06, 1.12) n = 42	n = 6*	0.67 (-0.02, 1.35) n = 23	n = 6*
19–35	0.93 (0.80, 1.07) n = 14486	0.57 (0.40, 0.73) n = 900	0.63 (0.40, 0.86) n = 267	0.78 (0.57, 0.99) n = 321	0.70 (0.40, 1.01) n = 130
36–50	0.80(0.66, 0.94) n = 8307	0.57 (0.40, 0.74) n = 766	0.57 (0.34, 0.81) n = 241	0.72 (0.44, 1.00) n = 151	0.44 (0.12, 0.76) n = 106
51+	0.61 (0.46, 0.75) n = 2687	0.58 (0.30, 0.86) n = 142	0.35 (-0.15, 0.85) n = 35	1.41 (0.54, 2.27) n = 17	1.18 (0.44, 1.92) n = 17

Table 24: *Predicted Change in Harassment and Stalking by Ethnicity and Age. Values represent months of abuse with 95% confidence intervals in parentheses. *Indicates the sample size is low*

Intersectional Identity Analysis
The intraclass correlation coefficient (ICC) for the identity strata was 0.012 before adding in the fixed effects, indicating that approximately 1.2% of the variance in change in harassment and stalking was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0.0008. This suggests that 0.08% of the variance in change in harassment and stalking remained attributable to between group

differences, with most of the variance explained by individual identity characteristics. The ICC for service-provider was 0.065, suggesting that 6.5% of the variance in change in harassment and stalking was attributable to differences between service providers.

One identity stratum was found to have random intercepts significantly greater than zero, indicating that individuals in this groups experienced significantly higher reductions harassment and stalking from intake to exit than predicted by the fixed effects alone. This included:

> **White, heterosexual females aged 19-35 without a disability** – the estimated random intercept for this stratum was 0.006 (*SE* = 0.02, 95% CI: 0.01 to 0.09) suggesting that members of this group experienced, on average, a higher predicted score for reduction in harassment and stalking from intake to exit of 0.006. This was higher than the predicted value of 2.30 based on the fixed effects alone (n = 12,579).

Level of Jealous and Controlling Behaviour at Intake

Jealous and controlling behaviour severity was measured on a 4-point ordinal scale[3]. There was moderate variability in jealous and controlling behaviour levels across services. The intraclass correlation coefficient (ICC) was .148, indicating that approximately 14.8% of the variance in this outcome was attributable to differences between service providers. The random intercept variance was 0.20 (SD = 0.44), and the residual variance was 1.14 (SD = 1.07). The marginal R^2 (variance explained by fixed effects) was .007, and the conditional R^2 (variance explained by both fixed and random effects) was .153, suggesting that individual-level characteristics explained a small proportion of variance in intake scores, while accounting for clustering by service provider meaningfully improved model fit.

Several individual-level characteristics were significantly associated with the level of jealous and controlling behaviour at intake. Gender was a significant predictor with male victim/survivors having significantly lower levels of jealous and controlling behaviour recorded at intake compared to female victim/survivors (β = -0.21, 95% CI [-0.27, -0.15], $p < .001$).

Age was also significantly related to this outcome. Compared to those aged 36–50 (reference group), individuals aged 19–35 had higher levels recorded (β = 0.07, 95% CI [0.04, 0.10], $p < .001$), while those aged 51 and older had significantly lower levels (β = -0.15, 95% CI [-0.19, -0.11], $p < .001$). Victim/survivors under 18 also had significantly higher levels at intake (β = 0.16, 95% CI [0.08, 0.25], $p < .001$).

Ethnicity was significantly associated with the level of jealous and controlling behaviour recorded at intake for one group. Compared to White victim/survivors, only individuals from Other ethnic groups had significantly higher levels of jealous and controlling behaviour recorded (β = 0.14, 95% CI [0.01, 0.27], $p = .041$). There were no significant differences for those identifying as Asian or Asian British ($p = .532$), Black, African, Caribbean or Black British ($p = .223$), or Mixed/multiple ethnic groups ($p = .138$).

Disability status was not significantly associated with levels of jealous and controlling behaviour ($p = .591$).

Sexual orientation was significantly associated with the level of jealous and controlling behaviour recorded at intake. Compared to heterosexual victim/survivors, those identifying as bisexual (β = 0.11, 95% CI [0.01, 0.21], $p = .033$), gay (β = 0.23, 95% CI [0.04, 0.42], $p = .019$), and lesbian (β = 0.17, 95% CI [0.02, 0.32], $p = .024$) all had significantly higher levels of jealous and controlling behaviour recorded at intake.

Finally, the year the case was opened (centred around 2020) was significantly associated with the outcome, with more recent cases showing slightly lower levels of jealous and controlling behaviour (β = -0.01, 95% CI [-0.019, -0.005], $p = .002$), suggesting a modest downward trend over time

Interaction Effects

No interaction effects explored in this analysis were not found to significantly influence levels of jealous and controlling behaviour recorded at intake.

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[3] 1 = no behaviour, 2 = standard level, 3 = moderate level, 4 = high level), with higher scores indicating greater severity

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.018 before adding in the fixed effects, indicating that approximately 1.8% of the variance in level of jealous and controlling behaviour at intake was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to near 0 (1.1×10^{-14}), which suggests that there were negligible systematic differences in the level of jealous and controlling behaviour at intake reported across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.143, suggesting that 14.3% of the variance in level of jealous controlling behaviour experienced at intake was attributable to differences between service providers.

Change in Jealous and Controlling Behaviour from Intake to Exit

A multilevel model was used to examine the relationship between victim/survivors' identities and the change in level of jealous and controlling behaviour experienced between case opening and case closure. Change in jealous and controlling behaviour was calculated by subtracting the level at case exit from that at intake[4].There is modest between-service variability in jealous and controlling behaviour change scores. The intraclass correlation coefficient (ICC) was .112, indicating that 11.2% of the variance in change in jealous and controlling behaviour was attributable to differences between services. The random intercept variance was 0.182 (SD = 0.43), and the residual variance was 1.539 (SD = 1.24). The marginal R^2 (variance explained by fixed effects) was .007, and the conditional R^2 (variance explained by both fixed and random effects) was .112. These results suggest that individual-level characteristics accounted for a small proportion of the variation in change in jealous and controlling behaviour, though including service-level clustering modestly improved model fit.

Several individual-level characteristics were significantly associated with changes in jealous and controlling behaviour. Gender was a significant predictor, with male victim/survivors experiencing significantly smaller reductions in jealous and controlling behaviour than female victim/survivors (β = -0.23, 95% CI [-0.32, -0.14], $p < .001$).

Age was also significantly associated with this outcome. Compared to individuals aged 36–50 (reference group), those aged 19–35 experienced significantly greater reductions in jealous and controlling behaviour (β = 0.13, 95% CI [0.09, 0.17], $p < .001$), while those aged 51 and older experienced significantly smaller reductions (β = -0.10, 95% CI [-0.16, -0.04], $p = .002$). Those under 18 also experienced significantly greater reductions (β = 0.20, 95% CI [0.08, 0.32], $p = .001$).

Ethnicity was not significantly associated with change in jealous and controlling behaviour. There were no significant differences between White victim/survivors and those identifying as Asian or Asian British ($p = .993$), Black, African, Caribbean, or Black British ($p = .990$), Mixed or multiple ethnic groups (p = .623), or Other ethnic groups ($p = .144$).

Disability status was significantly associated with change in jealous and controlling behaviour. Victim/survivors with a disability experienced significantly smaller reductions compared to those without a disability (β = -0.07, 95% CI [-0.12, -0.02], $p = .008$).

Sexual orientation was not a significant predictor of change in jealous and controlling behaviour. There were no significant differences between heterosexual victim/survivors and those identifying as bisexual ($p = .511$), gay ($p = .134$), or lesbian ($p = .202$).

The year the case was opened, centred around 2020, was not significantly associated with changes in jealous and controlling behaviour ($p = .778$), indicating that time trends did not have a notable effect on this outcome.

Interaction Effects

Interaction effects that were found to significantly influence the change in jealous and controlling behaviours experienced from intake to exit are listed below. The following interactions were not found to be significant:

[4] a higher positive value indicates a greater reduction in jealous and

- Ethnicity and disability
- Age and ethnicity
- Age and sexuality

Ethnicity and Sexuality
A significant interaction between sexual orientation and ethnicity indicated that bisexual women from Black / African / Caribbean / Black British ethnic groups reported significantly higher reductions in jealous and controlling behaviour from intake to exit than would be expected based on the independent effects of sexual orientation and ethnicity alone (β = 1.04, 95% CI [0.12, 1.95], *p* = .027).

Predicted values show this compounding effect. Among heterosexual individuals from Black / African / Caribbean / Black British ethnic groups the predicted change in jealous and controlling behaviour was 1.04 (95% CI [0.83, 1.26]), lower than White heterosexuals at 1.09 (95% CI [0.92, 1.26]). However, among bisexual women in this ethnic group, the predicted change in level of jealous and controlling behaviour increased to 2.13 (95% CI: 1.22, 3.03), in contrast to 1.04 among heterosexual women of the same ethnic group. However, these findings should be interpreted with caution due to the small number of victim/survivors who identified as bisexual from Black / African / Caribbean / Black British ethnic groups (n = 18).

Sexuality	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
Heterosexual	1.09 (0.92, 1.26) *n = 25505*	1.07 (0.89, 1.25) *n = 1817*	1.04 (0.83, 1.26) *n = 526*	1.03 (0.82, 1.25) *n = 493*	1.23 (0.97, 1.49) *n = 249*
Bisexual	1.14 (0.91, 1.37) *n = 377*	0.59 (-0.18, 1.35) *n = 23*	2.13 (1.22, 3.03) *n = 18*	1.06 (-0.05, 2.17) *n = 13*	*n = 3**
Gay	0.86 (-0.02, 1.74) *n = 19*	*n = 0*	*n = 0*	*n = 0*	*n = 0*
Lesbian	1.22 (0.93, 1.52) *n = 193*	*n = 6**	*n = 2**	*n = 2**	*n = 3**

Table 25: *Predicted Change in Level of Jealous and controlling Behaviour Safety by Ethnicity and Sexuality. Values represent months of abuse with 95% confidence intervals in parentheses. *indicates the sample size is low*

Intersectional Identity Analysis

The intraclass correlation coefficient (ICC) for the identity strata was 0.014 before adding in the fixed effects, indicating that approximately 1.4% of the variance in the change in level of jealous and controlling behaviour was attributable to differences between identity strata. After including the fixed effects, therefore, adjusting for individual identity characteristics, the ICC for identity strata decreased to 0, which suggests that there were no systematic differences in the change in level of jealous and controlling behaviour from intake to exit across identity strata groups when accounting for individual-level factors. The ICC for service-provider was 0.101, suggesting that 10.1% of the variance in change in level of jealous controlling behaviour experienced at intake was attributable to differences between service providers.

Qualitative Data Analysis

Summary of Key Qualitative Findings

The analysis of the qualitative analysis identified the following themes and sub-themes

#	Theme	Sub themes	Description
1	Self-Directed Safeguarding	• A Learnt Distrust of Services • Utilising reporting pathways to meet individuals where they are	Barriers for reporting domestic abuse exist and there is a learnt distrust of services. This leads to different reporting pathways emerging for marginalised identities, experiencing abuse for

		• Minimisation and Normalisation • Help Seeking at the Point of Crisis	longer and help seeking at the point of crisis.
2	Needing a Voice when Voiceless	• Isolation • Unhelpful Responses • External Validity Seeking	When help-seeking victim/survivors with marginalised identities can experience additional barriers to receiving support. They can experience additional isolation, receive unhelpful responses and experience delays in being believed.
3	One Size Fits None	• Communication Gap • Available But Not Accessible • Available but Not Appropriate • Not Knowing One's Own Identity • Homogenous View of Identity • Lack of Authentic Victim/Survivor Voice • Siloed Services and Siloed Training	Services do not always meet the specific needs of individuals. This can be due to a lack of understanding and communication breakdowns, not being accessible or appropriate, not being tailored to the needs or a lack of awareness of identity. There is a paradox of lots of training but it not being specialised to meet the needs of intersectional identities.
4	Being Lost in the System	• From Pillar to Signpost • The Burden of Responsibility • A Cycle of Being Marginalised	An administrative burden exists for victim/survivors from marginalised identities which is complex and vast and they have to fill the gap in order to receive support.
5	Weaponising Identities	• Weaponisation of Identity by Perpetrators • Weaponisation of Identity by Services • Hiding Identities	Marginalised identities form part of the abuse from perpetrators; but these same identities may be being used to minimise abuse by professionals.
6	A Single Point of Light	• Individuals Within the System • Logistical Support • Emotional Support • The Burden of Support	Victim/survivors often describe the 'one' professional that made the difference for them, and filled the gaps in the system.

Key Findings by Research Question

How do referral pathways and length of abuse differ by intersecting identity?

- A learnt distrust of services provides a barrier for victim/survivors wanting to disclose domestic abuse to authorities. This increases the length of time before victim/survivors seek help and results in some victim/survivors only approaching authorities at the point of crisis.

- There are often missed opportunities with victim/survivors disclosing domestic abuse several times before receiving support.

- Referral routes into services for marginalised communities have been adapted to 'meet' individuals where they are and utilise disclosure opportunities and overcome a learnt distrust of services, such as Facebook groups and other social media platforms.

- Victim/survivors search for their experiences to be validated by external parties and want to be believed. This can be the time when victim/survivors first come to realise and acknowledge they are being abused. This is often reliant on exceptional individual professionals providing emotional and logistical support rather than a systematic, structured, resilient approach.

How does risk profile differ by intersecting identity?

- Victim/survivors often seek help when the abuse escalates, they are at crisis point, or following physical abuse.

- Victim/survivors can have their marginalised identities used against them by their abusers or abusers may use victim/survivors' transitional identities, such as pregnancy, as a means to further their abuse.

- Perpetrators use marginalised identities to form part of the abuse such as threats to reveal hidden identities, a tool for wider manipulation such as withholding vital equipment and medication and access to services. This hostility to identity is then often reinforced by professionals when seeking help through negative responses and minimisation of experiences and a lack of understanding of the impact.

How do victim/survivors needs differ by intersecting identity?

- Victim/survivors needs differ by intersecting identity and services and organisations are not routinely meeting these needs. Communication barriers and a lack of understanding for different intersectionalities and marginalised identities lead to misunderstandings and disengagement by victim/survivors.

- The services being offered may not be able to be utilised by all victim/survivors with marginalised identities as they are designed for a generic view of a victim/survivor. Services may not be accessible for all individuals and can present a barrier to receiving support, with a lack of tailoring of services to meet individual needs. Numerous different examples were given on accessibility which included language, physical spaces, not meeting criteria, caring responsibilities, location. Services may also not be appropriate and may put individuals at an increased risk from the domestic abuse or from elements associated with their identity such as health or immigration status.

- Marginalised identities may be invisible to the victim/survivors when first seeking support. Some victim/survivors will elect to hide their marginalised identity, such as their sexual orientation or gender identity, from their abuser or service as a defence mechanism.

- To get the support they need, victim/survivors must fill in the gaps between organisations. Victim/survivors will act as the go-between for the different siloed services, meaning they have extra administrative and logistical burdens for each marginalised identity. This also means victim/survivors will have to re-explain their case and trauma to many different services.

- Individuals value 'by and for' services. However, services are often siloed. Each service often specialises in one distinct element of support, such as housing, benefits, or criminal justice, or each service specialises in one distinct demographic to support, such as men, Black and racially minoritised victim/survivors, or LGBT+ victim/survivors.

How do outcomes differ by intersecting identity?

- If victim/survivors disclose their abuse, they may be met with unhelpful responses from support networks, including friends, family, and services. These unhelpful responses may cause the victim/survivor to not seek other support options. This may mean they stay in the abusive relationship for longer or may make them disengage with their support network altogether.

- Impacts of domestic abuse for individuals with marginalised identities can be long-lasting and vast. As a result of domestic abuse, some victim/survivors will experience impacts which result in further marginalised identities such as physical health conditions, mental health conditions, homelessness, or unemployment. These can compound the effects of intersectionality when help-seeking in the future.

- Victim/survivors are isolated because of the abuse they are experiencing. For victim/survivors within certain marginalised communities, this isolation is an exacerbation of base-level seclusion due to their identity.

Qualitative Analysis

Theme 1: Self-directed Safeguarding

"This is only scratching the surface of the issues that I've had with officialdom, as a result of identity stuff." – Victim/survivor

Many of the interviews focussed on the barriers to people with intersecting identities seeking domestic abuse support. Interviewees identified that *conventional* pathways for reporting domestic abuse, such as police, hospitals, or social workers, are more difficult to approach for victim/survivors with marginalised identities. This is because, as well as the usual barriers to reporting domestic abuse, "prejudice [comes] into it as well".

One professional highlighted that victim/survivors may have internalised this prejudice and may normalise their experience of neglect. This may make it difficult for victim/survivors to identify the abuse themselves, and this acts a further barrier for disclosure. These barriers have led to the emergence of improvised reporting pathways for victim/survivors, many of whom never report the abuse or only turn to institutions at a point of crisis

A Learnt Distrust of Services

Many of the interviewees highlighted a lack of trust from victim/survivors towards the services to support them during domestic abuse. These services included the police and government, who were not trusted to receive a disclosure.

"They [victim/survivors] are thinking 'How can I get help? I have no access to public funds – our government will not help me.'" – Professional

"The first thing wasn't going to be calling the police" – Victim/survivor

Professionals highlighted that this mistrust was particularly impactful when the victim/survivor had children. There was a fear of authorities removing the children after a disclosure of domestic abuse.

"As soon as you mention children, there's big misconceptions that children's services are going to take your children" – Professional

In some cases, the fear of being separated from children was realised. Professionals discussed cases where children were removed from their mothers and one victim/survivor talked of estrangement from their children. This estrangement, they believed, was caused by the inadequate response they received after reporting her domestic abuse to authorities.

"…some people that came in through referrals, that had had their children removed, some of them didn't succeed on the programme; they went on like a downward spiral, because… they had nothing to live for, then." – Professional

"But every Christmas, birthday, Easter, Valentine's… I send them all an individual text – I hope it's still their number, it may not be their number still – 'Happy… whatever, love and best wishes, Mum', and that's all I can do." – Victim/survivor

Professionals recognised that victim/survivors have had negative experiences with domestic abuse services and that this bad experience may be the cause of the victim/survivors' distrust. Some professionals took this idea further and touched upon the systemic issues which cause these bad experiences or make these bad experiences more likely for people with marginalised identities. Some professionals highlighted discrimination within the institutions themselves. One professional identified the systemic issues within an organisation are "passed on" to victim/survivors, using the example of "institutional racism" within the police.

"When they did report, nothing was ever done" – Professional

"… I hate to say it, because it's really sad for services, but the amount of passive-aggressive sort of… homophobic jokes you hear in the office" – Professional

"{Location} police recently recognised that there is institutional racism…. and it inevitably… erm… passes on to how victims get treated" – Professional

This point was exemplified by one professional who explained her experience of seeing police carrying out honour-based assessments for any ethnic minority domestic abuse case, "without realising the actual implications of completing an honour-based assessment, and what that will mean for the family". Explaining that, because of this action by the police, "suddenly, their risk has escalated – usually unnecessarily – it means more services get involved". This leads the victim/survivor and their family to think "Well, I'm never going to report again, because this is just… this is not what I was expecting…". As one professional put it: there is "all the historic kind of… lack of trust around services" which makes it harder for certain victim/survivors who are "trying to engage in a service where you might feel that they don't necessarily kind of want to engage with you". Indeed, this was echoed by another professional who identified that there is reluctance from one service to work with ethnic minorities *and* that ethnic minorities are underrepresented in official routes to safety.

"I, as a professional, don't see as many ethnic minorities coming through, at all, through to any services…" – Professional

This effect is not limited to Black and racially minoritised victim/survivors. In our interviews, professionals used the examples of autistic and disabled people struggling to interact with police, and the LGBT+ and traveller community feeling they couldn't approach authorities. This distrust, professionals explained, leads to fewer victim/survivors approaching services.

"Autistic and disabled, actually, really struggle with making… going… interacting with the police, and engaging with the police." – Professional

"I do find working with LGBTQ+ to be massively rewarding, but it's… very, very few and far between that actually come forward." – Professional

The interviews with victim/survivors took this idea even further and provided further insight into the roots of this distrust. When talking to victim/survivors, it becomes apparent that this distrust is not just learnt by individuals after some isolated, bad experiences with specific services. People from marginalised communities may have learnt to distrust institutions as a method to safeguard themselves from societal inequalities. During the interviews, victim/survivors described other, non-domestic abuse related experiences where they received unhelpful responses. One person gave the example of reporting bullying being ignored when the person coming forward was autistic. Another interviewee talked of serious health problems being dismissed when one is "female and young". One victim/survivor articulated this idea of *protective distrust* with regards to disability. This experience, of unhelpful responses in all walks of life for people with intersecting identities, was recognised and summarised by one professional.

"[there is a] barrier created by fear of how they'll be judged, because they're already judged" – Professional

This learnt distrust of services is so influential that some victim/survivors even talked of staying silent to *protect their abusers* from the prejudice within these systems.

"… I've found myself defensive about my abuser – feeling this weird need to protect him" – Victim/survivor

Utilising reporting pathways to meet individuals where they are

Many victim/survivors with intersecting identities may not use conventional reporting pathways. Services supporting marginalised communities have adapted reporting mechanisms to reach individuals in different ways and in places that they may already be and support disclosures. One professional gave the example of immigrant women from the Philippines, Vietnam, Thailand, and Burma seeking help via social media.

"We receive them [disclosures] through email, and on personal message on our social media – we have Facebook, Twitter, Instagram and LinkedIn as well" – Professional

The use of social media as a common point of contact was also echoed by other professionals. One professional explained the breadth of their community which consisted of "a network of around about 20,000 followers, and … a closed Facebook group of 6,000". These disclosure routes are often run by community groups and 'by and for' orgs who have similar lived experience as the victim/survivors seeking their help. This lived experience usually includes being from the same marginalised community and having experienced domestic abuse themselves. One professional explained how she "work[s] quite well with ethnic minority communities, … because [she's] from the Middle East". The Facebook group set up for Southeast Asian women experiencing domestic abuse provides another example. This trust through shared identity means these online groups are sometimes the first port of call for victim/survivors within this community.

"It's like word of mouth from women who already experience that I've helped them, and has become successful, so they recommend me if there's some instances that happen within their friend circle or community." – Professional

"With Filipino community, … sometimes we are the first one who rescue them" – Professional

Alongside shared identity between victim/survivor and professional being important for immigrant and neurodivergent communities, interviewees identified the importance for disability and gender. This sense of shared identity and shared experience is often missing from larger institutions which, as one victim/survivor explained, can be unrepresentative.

"the police are very… it's very male-orientated" – Professional

Although these improvised networks provide essential pathways for some victim/survivors to report, they are makeshift and not universally accessible. As one victim/survivor put it, "they can't do miracles". Professionals highlighted that these improvised services often lack the information, powers, and authority of more official routes to safety, such as the police.

"And being part of the police, I have found it actually is really quite effective, and you can get a hell of a lot done… because… I'm doing exactly the same job as I did in community, but my email address is different, and people pay attention, and that's really sad. So, if I'm sending an email to say, 'I need the locks changed, tonight' it will get done" – Professional

Minimisation and Normalisation

One professional highlighted that the same prejudice which leads to a distrust in services can be internalised by members of the marginalised community. The example they described concerned the internalised ableism they have seen regarding disability and neurodivergence. This internalised prejudice acts as a further barrier to seeking support because it compounds the fear the victim/survivor may not be believed or blamed for the abuse.

"That [prejudice] is internalised as well, so you sort of sit there and think, 'Well, that's the stereotypical view, so that's how people are going to view me', and that all gets internalised over the years. And it creates a huge barrier." – Professional

Recognising abuse can be difficult for any victim/survivor, especially while it is happening. For those with intersecting identities, external and internalised prejudice may further complicate this process. One victim/survivor explained they thought the abuse was inherent to them while others believed the abuse was their own fault. One victim/survivor explicitly linked the previous trauma they had experienced to the self-blame they were currently experiencing during their abuse.

"I still didn't recognise it was abuse; I kind of thought it was me." – Victim/survivor

"I had a lot of trauma in my history, and I think that led me to blame myself for things when they started to happen." – Victim/survivor

During the interview, they explained that this was a *learnt behaviour*. The victim/survivor explained that people with marginalised identities, are "trained" to normalise and accept abuse and this was echoed in other interviews.

"The domestic abuse was… normalised" – Victim/survivor

"They [victim/survivors] actually need to know that they're not to blame – they really need to understand that" – Professional

Help Seeking at the Point of Crisis

The internal and external barriers to disclosing domestic abuse lengthened the experience of victim/survivors interviewed.

"it was a long, long time; it probably went on for about 8 years, until I kind of saw it as any kind of abuse really" – Victim/survivor

If the length of the abuse does not increase the likelihood of reporting, then the severity of the abuse may. It was common among the victim/survivors we interviewed that they only contemplated contacting the police at the point of physical violence, arguably the most recognisable form of DA.

"The first time I called them… well, I called 999; my partner slapped me, and it was actually the first time he was physically… like, violent towards me. So, I got really, really scared." – Victim/survivor

Even at the point of crisis, one victim/survivor explained that they didn't seek support because they continued to normalise the behaviour.

"I think I still didn't really grasp how serious what happened to me was, and how ...you know... I mean, he nearly killed me, and I… I didn't realise, at the time, I was like, 'Ok, I'm alive, it's fine, let's keep going!'" – Victim/survivor

Both victim/survivors and professionals highlighted the delay in reporting. It is unclear whether the professionals supporting victim/survivors link the delay in disclosing abuse with the victim/survivor's learnt distrust of services. In some interviews, professionals linked the delay to individual decision-making as opposed to a systemic issue.

"The police asked me why I didn't report it sooner" – Victim/survivor

"I try to advise the women, if they have to decide on their own; not to wait for a bigger escalated conflict." – Professional

Theme 2: Needing a Voice when Voiceless

"when you're not on your own, and you have someone – just one person – who understands, it's a massive relief" – Professional

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During the interviews, victim/survivors explained that after overcoming the barriers to recognising abuse, they either had no-one to disclose to, or their disclosures were met with unhelpful responses. Victim/survivors described their experiences of isolation and having their abuse minimised or dismissed by services and individuals who received their disclosure. This experience, of being disregarded when in a marginalised community, makes external validation such a powerful tool for victim/survivors with intersecting identities.

Isolation

The isolation some victim/survivors experience is a factor in normalising the abuse. One professional explains "they don't have any outsiders' advice".

"When you're socially isolated, and have got a very, very small friendship network, or not a lot of family around, you don't have that opportunity to process, because you're not getting chance to talk to people." – Professional

"I fell out with friends because they didn't like him, and so then I would be choosing, so I was in a lot of situations where I felt I had to choose my friends to keep my family, and that was really painful and difficult." – Victim/survivor

As well as this, many victim/survivors explained that the abuse they experienced increased levels of isolation. Friends and family would distance themselves from the victim/survivor or the victim/survivor would have to choose between their abuser and their support network. Increased isolation was not merely a by-product of abuse, but a common tactic used by the abuser. One victim/survivor described how the abuse started during the pandemic when they were isolated from friends. Many other victim/survivors explained the perpetrator actively took steps to isolate them from their support networks.

"I've been cut off by family, now" – Victim/survivor

Some victim/survivors explained that their support system was actively used by the abuser to cause further trauma, a psychological manipulation tactic known as *triangulation*. This co-opting of a support network was not confined to the period of abuse. Many of the victim/survivors described the long lasting, alienating impacts of domestic abuse, even after the abuse had finished.

"Family or friends, … – whether they know it or not – … are being utilised as informers, to inform him about myself and what I'm doing, and where I'm going, and everything else." – Victim/survivor

"I'd spoke to some friends, but he was very manipulative, you see, very quiet in his way… and… because I was very… erm… as I said, eccentric and extrovert, they thought it must be me" – Victim/survivor

The manipulation of a victim/survivor's support network can increase risk if attempts at disclosure or help-seeking are reported back to the perpetrator. One professional highlighted that the social impacts of reporting abuse may be worse for victim/survivors with a smaller or more insular community or network, which they explained was often true of marginalised communities. In some cases, the victim/survivor had to choose to distance themselves from their support network because of the environment it had become.

"Well, talking to people was good, but then they… kind of it got back to the perpetrator, and then obviously that put me at more risk because they knew about it, and they just weren't very sort of helpful; there wasn't really a lot they could do about it, they said." – Victim/survivor

"Your communities are so small; if you're from a [specific community] and the police are called, everyone's going to know about it." – Professional

This isolation may be felt by any victim/survivor of domestic abuse and the tactics of separation and manipulation may be used by any abuser. However, this isolation is likely to be exacerbated for those victim/survivors with marginalised identities. This is because some people with intersecting identities have a base level of isolation due to societal prejudice or logistical necessity. The interviewees provided insights into the isolation they felt in life before the abuse started.

"We were incredibly isolated because of [specific needs]." – Victim/survivor

Victim/survivors explain that their isolation does not begin with domestic abuse but is worsened by it. In some cases, the abuser is the only support network for the victim/survivor. Before, and during the abuse, this person represents a significant proportion of the victim/survivor's social network. As well as the social aspect of this relationship, the abuser can act as the only financial or medical lifeline for the victim/survivor. Leaving the relationship would mean leaving this security and sometimes this is not viable.

"Because if you're not able to finance yourself to leave a relationship, you're not able to get the housing you need; you're not able to get a car to get to work; you're not able to have your own bank account." – Professional

Not only does this allow the abuser to control and isolate the victim/survivor to a greater extent, but it provides a further barrier to the victim/survivor reporting the abuse. If they can't stop the abuser from abusing them and they are forced to leave, the victim/survivor may also lose their entire support network. As interviewees explained, this can have devastating effects on their connection to the outside world and their finances.

"With neurodivergent women, that person [the abuser] might be the only person they've got in their life. It's not just their carer; it's also the only person that they're connected to in the world. So, there's often this… erm… 'resistance' I suppose is the word, to actually speak up about it." – Professional

"I didn't think that [leaving] was going to be economically viable." – Victim/survivor

This fear of harmful side-effects to reporting abuse was encapsulated by one person interviewed who said they reached out to a friend but only did so because they knew that specific friend wouldn't do anything. The isolation felt by so many victim/survivors provides further reason for the emergence of the improvised networks described in section one. These groups are not merely a means to report domestic abuse, but act as the support network where this has been lost, manipulated, or never existed. These groups are made more effective when they provided a shared identity or experience, as expressed by one victim/survivor.

when you're isolated, you don't know that there's anyone else; you don't think that anyone else is going through what you're going through; you think you're the only one, and no-one will understand you" – Professional

Unhelpful Responses

A support network can act as a third party to identify signs of abuse. This is useful when a victim/survivor does not recognise the abuse or is not comfortable disclosing the abuse. Even if a victim/support does have a support network, there is no guarantee this network will respond well to identifying abuse. Victim/survivors explained that people within their support networks knew something was wrong but did nothing.

"And other friends, it turns out, had been very worried about me. There was one particular little friend group where they had been worrying intensely about me for years." – Victim/survivor

Where victim/survivors overcome the barriers to reporting domestic abuse and actively disclose to someone within their support network, they are likely to be faced with unhelpful responses. This experience was described by victim/survivors who told their friends and family.

"I wouldn't say she 'dismissed' my experience, but she minimised my experience." – Victim/survivor

This experience was not exclusive to social contacts. Victim/survivors revealed that disclosures to official institutions often resulted in unhelpful responses as well.

"I remember the Judge in the Court said to me, 'You shouldn't be in this situation" – Victim/survivor

"Whenever I would explain concerns I had, she [my solicitor] kept not really taking them seriously – or brushing them aside" – Victim/survivor

These experiences help to explain the learnt distrust described by victim/survivors in the previous section. The fact that these victim/survivors were from marginalised communities may have played an implicit role in the unhelpful responses by the judiciary, police, and healthcare workforce. Other examples provided by professionals and victim/survivors, illustrate the times when discrimination is more explicit in minimising domestic abuse. In some cases, misogyny and racism likely contributed to the minimisation of the abuse.

"The {Service} was rubbish. Things that I wanted them to do… they didn't follow through, and that was down to… ignorance, racism" – Victim/survivor

These unhelpful responses can result in the victim/survivor disclosing multiple times, waiting until they get a helpful response. Victim/survivors explained the lengths to which they had to go, to be believed.

"I went to A&E a few times, …" – Victim/survivor

"And it took me 7 disclosure attempts before someone actually took me seriously." – Victim/survivor

As well as the increased time to get support, these unhelpful responses may re-instate the barriers which were overcome by the victim/survivor to disclose in the first place. As one professional explained, "if the first person you're calling is downplaying it, you yourself are going to not think it's much of an issue". If institutions minimise a victim/survivor's experience of domestic abuse, the victim/survivor may normalise the abuse they are experiencing or may learn to distrust that institution, or institutions in general. One victim/survivors explained that they lost faith in the police during multiple disclosures and often questioned their response to the abuse.

"I mean, the police was extremely unhelpful! … so yeah, I gave up, with the police." – Victim/survivor

"I was just like, 'Ok, maybe I'm crazy, I don't know!' And I started to go in this cycle like, 'Oh, it was just a slap; maybe it's ok, I over-reacted' etc." – Victim/survivor

Another victim/survivor shared similar sentiments as they explained they gave up trying to seek support. One victim/survivor explained that default responses, which may be helpful to one group, may not be helpful to another. They gave the example of "mainstream feminism" advocating for independence for women after abuse but that this was unhelpful to women with restrictive disabilities. In another case, a victim/survivor highlighted that services wanted them to leave the abusive relationship but failed to identify that this would put them at greater risk due to their disability.

External Validity Seeking

The isolation and unhelpful responses faced by victim/survivors with intersecting identities may make external validation of their trauma a more significant factor, specifically impactful in the route to safety of marginalised communities. Because their experiences have often been minimised by themselves and others, having a third party acknowledge their abuse can be extremely powerful. One victim/survivor explained the importance of having a service "validate" them. Lacking social contact or approachable services, one victim/survivor sought this independent validation from a website questionnaire where, for the first time, their abuse was externalised and substantiated.

"I think the support that I had changed my life, in regards to, like, {Service} and being able to have somebody validate, like… even that was powerful!" – Victim/survivor

"I got really scared, and I went online, and I actually did like this kind of questionnaire; and I remember I did this on my phone, and the result came back as like ...you know... 'What you are experiencing is abuse', and I was like… 'Oh my god!' like, 'I'm not crazy!'" – Victim/survivor

Professionals, too, recognise the impact of having a third party or "reputable institution" validating the experiences of victim/survivors.

"If the police is not involved, they will stick with the marriage. But if it's escalated with the police, and the police will take action to put the perpetrator in bail, then that's the time they will realise, 'Oh, yeah, I am experiencing a big domestic violence, domestic abuse, in my life, because the police said so, my partner has been bailed, and there's a probable cause that I've been experiencing domestic violence'." – Professional

"we're getting a lot [of DA cases] where other professionals are involved and identify it, and then kind of bring to the survivor's attention" – Professional

One victim/survivor explained this validation can come from a something as simple as a professional carrying out a risk assessment. However, some professionals highlighted the pitfalls of risk assessments, such as the DASH, which may work to further minimise the abuse experienced by the victim/survivor if their abuse is psychological, financial, or emotional. This is because the DASH, they argue, is overly reliant on physical harm.

"And I wanted to kind of… get some sense of risk assessment" – Victim/survivor

"I think DASH is too heavily focused on the… kind of physical, immediate risk…" – Professional

"Victims who are over for like immigration purposes, their DASH's always come out lower… than kind of the risk actually is, because… you're assessing kind of more on the emotional, the psychological side" – Professional

Theme 3: One Size Fits None

"It's not us fitting into your box, it's making sure that box fits everybody."

Victim/survivors highlighted that the support they receive could be dictated by how they are perceived. If this perception didn't align with the "the classic narratives of abuse" then they struggled to get support. Victim/survivors suggested their identity could be a barrier to accessing services, if it did not fit the

“stereotype of … someone who has been abused”. The most dominant recurring example of this exclusion, described by both professionals and victim/survivors, was around the use of language.

“Again, unfortunately, this element of stereotype of expecting someone who has been abused to not be articulate or educated; there’s a stereotype of classism there.” – Victim/survivor

“I think being a professional, and again working in a very similar role, I think sometimes when I asked for help it was dismissed that I didn’t need it.” – Victim/survivor

Communication Gap

Professionals highlighted that the language used to support victim/survivors may not be accessible for certain communities and this presents as a barrier to support. Professionals provided the evident example of victim/survivors speaking a foreign language.

“There seems to be a general… erm… attitude of ‘It’s quite difficult to work with ethnic minority communities’, which makes… which makes it quite difficult, because you can see people wincing, as soon as they have to use Language Line, or they have to use an interpreter!” – Professional

A language barrier may cause logistical issues as well as communicative ones, with one professional explaining the difficulty in arranging interpreters in Court. As well as vocabulary, one professional highlighted the cultural language difference which presented as a barrier to support. This is either through the specific vocabulary of the communities or through that group’s cultural understanding of domestic abuse.

“If you’re going through the Courts and you need an interpreter, a lot of interpreters don’t want to come – it’s too far for them to travel ... and the court case is going to have to be pushed back now; probably by months, which is going to impact that victim’s… whole life!” – Professional

“Dispelling myths… is really hard with professionals, that an arranged marriage is not the same as a forced marriage, and that makes it a massive difference in how you talk to people.” – Professional

One professional provided the more hidden example of neurodivergent victim/survivors and their specific communication needs. Victim/survivors agreed that there was a communication-barrier, particularly regarding neurodiversity. One victim/survivor explained that the support services they accessed struggled to communicate with them and struggled to understand their communication needs. This communication barrier, where information was provided to neurodivergent victim/survivors in a non-accessible way, came up repeatedly in interviews. Victim/survivors with neurodivergence explained that this gap meant they lost track of paperwork, became overwhelmed, or didn’t identify the support that was being put in place. Victim/survivors explained that the support and paperwork didn’t feel tangible and that plans felt like they were happening around them. One victim/survivor highlighted that this communication barrier may be because professionals in support services are often neurotypical, with communication not catering to neurodivergent victim/survivors. The use of neurotypical communication styles is an example, of services using an assumed language which may not be accessible to victim/survivors from marginalised communities. One victim/survivor explained how different communication styles left room for mutual misunderstanding. Explained that a lack of emotion from the victim/survivor can be misread as indifference by a professional while at the same time a lack of specific feedback from a professional can be interpreted as “judgemental or suspicious” by a neurodivergent victim/survivor.

“...with neurodivergence, it’s communication needs; environmental needs; but also the different ways that they process information.” – Professional

“I had so much difficulty when I explained my communication needs” – Victim/survivor

Available But Not Accessible

Victim/survivors identified ways that their identity was a barrier to receiving help. Much like the linguistic case, some victim/survivors explained that support was available just not *accessible*. Professionals recognised this concern and accepted this was because support systems are not set up for victim/survivors with marginalised identities because they are “forgotten” or their situation “wasn’t recognised”. Examples included disability, neurodiversity, being a single parent and rurality.

“The disabled people struggled because they didn’t have the help or the support, or even any idea how to navigate anything, because their situation wasn’t recognised” – Professional

“Neurodivergent needs are often completely forgotten.” – Professional

"if they've separated and they have the children, they might not be able to attend evening courses" – Professional

"There's no youth clubs in the rural area; there's no community groups; no support groups." – Professional

The support systems are in place; they are just unobtainable to certain victim/survivors. One victim/survivor explained that community groups were inaccessible to them as a carer with specific time constraints. One professional gave the example of services providing support, but support which was ineffective to victim/survivors with neurodivergence because it failed to meet the sensory needs of the victim/survivors.

"If their sensory needs aren't met, then they're not going to be able to process what you're telling them." – Professional

"When you were sat in the consultation room, you could actually hear this 'hum' behind your ears, which – if there is a processing delay there – that would completely stop you being able to process communication." – Professional

One professional interviewed went on to explain that these support services need the skills to provide support to "how different brains process this information". As well as providing more accessible information for neurodivergent victim/survivors, one victim/survivor highlighted the need to provide more accessible information for victim/survivors who have difficulty with literacy.

"as soon as paperwork comes out, and it's really difficult where you're able to – under other circumstances – sit with a victim, and you can look through the paperwork together, if their literacy level is not at that level to be able to read some – to be fair – quite compact information, it's overwhelming; disengagement happens quite quickly, and the fear of being ostracised is too great." – Professional

This disengagement is particularly concerning, one professional went on to explain, due to the lack of services available. If a victim/survivor has felt "ostracised" by one service, they will likely have no other port of call. The lack of services is also a concern when the service needed by victim/survivors only caters to a specific demographic or doesn't meet the needs of certain demographics.

"{Service} is the only sexual trauma service in all of {Location}, so your options are extremely limited, as a victim! And {Service}, which is the sexual assault referral clinic, which is based in {Location}. But again, it's the only SARC in all of {County}" – Professional

"Teenage boys, or children with disabilities. Any disability, most refuges now I'm finding, progressively, they just can't cope. So, they won't take you." – Professional

"Some [refuges] will be really specific, 'Available to only Asian [victim/survivors]', … you've seen that, and like… which is not really fair, because 'If there is space, but this person is not Asian, you cannot take them'" – Professional

Available but Not Appropriate

As explained, some services are theoretically *available* but are not *accessible* to some marginalised groups. They exist they just can't be reached. Other times, interviewees explained, the support provided may be *appropriate* for some victim/survivors but is not for others. One professional gave the example of safety planning being designed for a generic victim/survivor and that this won't for everyone or consider their specific situation.

"There's no point saying to someone who lives in a one-bedroom flat, 'See if you can find a safe space to get into, to hide when things are escalating'; and if there's only 4 rooms in the whole place, and there's no locked doors, that's a wasted conversation!" – Professional

"And saying to people 'If you're able to hide a phone' – again, in quite cramped spaces – when your perpetrator is very controlling, and looks through all your things, those phones are often found, which leads to, again, physical escalations; sexual violence escalations" – Professional

They emphasised that some organisations don't "have the time, the capacity, to tailor a safety plan". When reviewing generic safety plans, they could "see where this has gone very wrong! ... you know... that this wasn't tailored". Professionals explained the need to tailor support to the individual and that small changes which are specific to the individual "make such a big difference".

"I think it just really has to be tailored; you have to really know the ins and outs, and the nuances, and the practicalities for each victim. Because if it's not safe for them to keep their… if they need an emergency bag to leave, can they keep it somewhere else? It's… it's really simple things, that can make such a big difference." – Professional

Not Knowing One's Own Identity

Some victim/survivors explained that they, themselves, didn't know of their own marginalised identity at the time of reporting the abuse. Victim/survivors gave examples of neurodiversity, gender identity, sexuality, and mental health issues. Where victim/survivors did not recognise their own marginalised identity, this may have made barriers to support even more difficult to overcome. As discussed in section one, some victim/survivors "have been convinced that everything that's happening to them is their fault". Where services are inaccessible or inappropriate, these same victim/survivors may attribute this to their own failings not the services' lack of accessibility to marginalised groups. This is particularly impactful for victim/survivors with intersecting identities, as one victim/survivor explained.

"At that point, I had no idea about even like… ADHD and masking, and probably like trauma and stuff" – Victim/survivor

Homogenous View of Identity

During the interviews, it was apparent that some services *do* ostensibly cater to people from marginalised communities. However, there was a risk that some services view marginalised communities as a homogenous collective. One professional explained that sensory needs are often viewed reductively.

"When we talk about 'sensory', people automatically assume deaf/blind, and sensory loss" – Professional

In some cases, this stereotyping is evidently harmful. A neurodivergent interviewee explained how many autistic people are caricatured as "stalkers" or as "aggressive". Whether or not a stereotype is derogatory, interviewees explained that the process of stereotyping itself is not helpful. One interviewee highlighted that services may view them as the cliché of their identity, and this intrinsically overlooks many of their individual needs.

"it's that recognition of different types of disability, and how they alter access needs." – Professional

The homogenous view of a victim/survivor's identity can lead to risk assessments being misjudged by the unwarranted inclusion of honour-based abuse in cases of Black and racially minoritised victim/survivors. This stereotyping may come from a lack of diversity within the institutions themselves.

"… if you are a predominantly White, British, Christian country, and a lot of people don't move around – there's not a lot of diversity down here – it's inevitable that you just haven't come into contact … with ...you know... people who are hijabi; people who are refugees; people who are from smaller enclaves, who tend to keep them to themselves" – Professional

A risk with this stereotyping, as was explained by one professional, is that this reductive view of each marginalised identity makes it easier for services to "speak for" a victim/survivor. By assuming each member of a specific community has set, homogenous needs, there is a risk that only these archetypal needs are supported. As a result, victim/survivors from marginalised communities have unmet needs, despite the service believing it is inclusive.

"People with disabilities seem to be 'spoken for' – people speak on their behalf – even if they don't actually know their full circumstances. They were quite quick to… see what's right in front of them, and say that 'It's this, this and this', and tell people what they need, and it's not actually what people need..." – Professional

Lack of Authentic Victim/Survivor Voice

Victim/survivors and professionals attributed the lack of accessible support to the absence of an authentic victim-voice within services. One professional highlighted the lack of opportunities for some victim/survivors to tell their story in general.

"When you're disabled or autistic, or… even marginally… you don't get the chance to tell your story that often."- Professional

Being understood and having one's voice heard, one interviewee explained, is essential for services to recognise and respond to domestic abuse. They explained that the reason services need to have an

authentic victim/survivor voice is that some barriers "would not be picked up unless you'd got that lived experience". It may be this lack of lived experience which leads services to provide generalised support which is not catered to the needs of marginalised communities. Professionals highlighted the importance of "working with [an] individual and asking them what they need, not just assuming".

"it's no good thinking that you know what disabled people need; you need disabled people to tell you what they need." – Professional

One professional suggested this gap could be bridged by embedding lived experience into support services which was echoed by victim/survivors. Without significant input from people with lived experience, they argue, support will not be effective.

"Simple as that; it's actually bringing people with that lived experience to talk to the service about what the barriers are" – Professional

Siloed Services and Siloed Training

Some general services may miss or overlook people with marginalised identities. One professional identified that law enforcement "are not doing particularly well at recognising intersectionality at all". However, services specifically designed for one marginalised community may miss or overlook people from other marginalised communities. As professionals explained, individual services may have too great a focus on their own area of expertise.

"All these different services … have their own priority and their own focus." – Professional

"Everyone just focusses on their own thing, and not necessarily looking at the whole picture." – Professional

Victim/survivors gave pertinent examples of this service-specific scope highlighting the absence of services suited to those experiencing blindness and domestic abuse; or those experiencing domestic abuse who were LGBT+. One victim/survivor explained that the difficulty in being supported by services is compounded by each marginalised identity you have.

"I think because of my blindness there wasn't that awareness there of how to support me. So, I think organisations that ...you know... work with domestic abuse and things have no awareness of disability and disability organisations had no awareness of domestic abuse." – Victim/survivor

"I've found all of these [different marginalised identities] have had a profound effect on my ability to get support, and the ways in which support sometimes is being blocked to me from ...you know... different organisations." – Victim/survivor

During interviews, professionals recognised this concern. They highlighted the siloed nature of services and explained the need to look at issues holistically. Professionals explained the lack of awareness surrounding intersectionality was due to a lack of appropriate training. One professional, who had intersectionality training, explained how it made "a big difference" and provided an example of integrated work between services.

"… most of the training I get is specific to the services that we give." – Professional

"I've had quite a bit of training on relevant things … but I've not actually seen anything that's specifically around intersectionality." – Professional

The gap between domestic abuse services and healthcare is one of examples where a victim/survivor is burdened with bridging an administrative gap to get effective support. Where this integration is missing, interviewees explained that the work-around for different needs being supported by siloed services was for victim/survivors to contact multiple services, one for each need. One professional identified that "usually when the women come to us, they're already working with other organisations".

Theme 4: Being Lost in the System

> *"This affects anyone who goes through domestic abuse, but the more vulnerabilities you have because of your identity, the less you're understood." – Victim/survivor*

Victim/survivors explained the extra work they must do to fill in the gaps of the system. Victim/survivors explained that because the system isn't joined up, they have multiple contact with multiple agencies and must take on the responsibility of being the go-between. This sense of being lost within the system can be exacerbated if the abuse and lack of response causes more transitional issues, such as health concerns.

From Pillar to Signpost

As discussed, many victim/survivors and professionals highlighted the siloed nature of support services. Where one service can't meet a victim/survivor's need, this is sometimes recognised. Professionals explained part of their job was "signposting [the victim/survivor] to different services." They provided many examples of this, including signposting victim/survivors to the GP, the pharmacist, the NHS, other domestic abuse services and accessing funding. One professional raised their concerns about this practice, explaining that they would ask themself "is that service accessible, or is that person just being given a phone number that they're then expected to phone up". One victim/survivor's experience suggested these worries are justified as they felt they were merely passed between services.

"Usually, we would hold people between… it's tackling the immediate issues, and minimising the risk, to be able to be passed on" – Professional

"This is a pattern I've seen – I ended up being passed between 3 different {services}. And from what I can make out, no {service} has the remotest clue what the support boundaries are; what the role or limitations of other {services} are" – Victim/survivor

Other victim/survivors echoed this sentiment explaining that frequent signposting between services had led the victim/survivor in circles or to a dead-end. Victim/survivors felt unheard as they repeatedly explained which services they had accessed already. Sometimes, as was explained by professionals, the services take signposting further and perform a direct referral to a different organisation. These referrals were often mentioned by professionals in the high-risk cases of domestic abuse.

"And she started telling me, 'Oh, you should go to the housing such-and-such; you should go to the Council' and these were places I'd already told her had turned me away, that there was nothing that they could do!" – Victim/survivor

"Some of the people were coming in with real big problems that actually, you needed that specialist support to be able to provide what they needed." – Professional

Even if signposting or referrals are effective, interviewees described "the long wait" between services. One professional highlighted the process can take a several months when referring to mental health services and another interviewee explained their long wait for their Personal Independence Payment (PIP). Victim/survivors explained that even if the referrals are made directly, and the time to access new services is short, there are still negative impacts of using many, siloed services. The first impact, as explained by victim/survivors, is that having to repeatedly describe one's experience is "re-traumatising".

"If it's mental health, a mental health service, it's easy to refer, but the response is very slow. Some of them will get a call after months, or they just give up on being on a waiting list." – Professional

"When I first met my first social worker, I'd spent like an hour spilling my guts, explaining my whole life story and my situation – when I met the Vulnerable Adults social worker, I was made to do the same thing again. We spent like 2 hours talking. And like… that was so re-traumatising. It's the way that the system... every part of the system expects you to tell your story over and over again." – Victim/survivor

Victim/survivors also explained that the experience of project-managing one's own support system can be physically and emotionally exhausting: an exhaustion compounded by the number of services one needs and how misunderstood one is. One victim/survivor described how they were made to be the go-between for a service and the abuser. When they refused, they explained that they were again signposted to a different service to no avail.

"I was trying to deal with my therapist and my medical team, and the social housing people." – Victim/survivor

The Burden of Responsibility

. The obligation for victim/survivors to make changes to their lives was raised in many of the interviews highlighting the burden of responsibility not falling on the perpetrator or on institutions. One

victim/survivor highlighted that there is an “onus” to make changes if you want support and that this is a barrier to identifying or reporting the abuse. One professional interviewed also recognised this “onus” on the victim/survivor and gave a litany of examples.

“I think the onus is so much on the victims; if they’re working, you’ve got to be able to find another job, or take a hiatus; if you have children, you’ve got to change their school; if their children have special needs, God help you, because no-one’s going to be able to support you” – Professional

Even something seemingly small, like having the locks changed, is the responsibility of the victim/survivor. As one professional explains, this comes with a financial burden which may be restrictive to that victim/survivor. As well as financial burdens, the changes forced onto victim/survivors can be hugely impactful emotionally. One professional highlighted the seldom considered implication for victim/survivors concerning their pets.

“People, most times, have to pay for it; and if you are on a low income, you actually can’t afford the £150 fee to come and change your locks. So, a lot of onus is put on victims, and sometimes maybe they just kind of say, ‘It’s just not worth it; it’s too much hassle’.” – Professional

“She really had to go into refuge, but she couldn’t leave her dog with anyone. So then, she had to make the horrendous decision, ‘Do I put my dog down and go into housing?’ and ultimately, she said, ‘This is the last thing I have; I cant. I. Can. Not…” – Professional

One interviewee explained how they had to give up their career, not due to the abuse directly, but as a measure they had to take in response to the abuse to remain safe. Other victim/survivors explained how they had to make significant changes to feel safer during and after the abuse or to mitigate against the ongoing impacts of the abuse. This included leaving their home, changing their lifestyle including hobbies and careers.

“I made security and people at Uni aware and stuff, so I think I minimised that risk.” – Victim/survivor

“I got to the point where I just walked out, because I didn’t want to disrupt the children, because that was the home base. And I went back every night, to cook dinner, still.” – Victim/survivor

Another interviewee explained that victim/survivors are burdened with “paperwork after paperwork after paperwork” to get support. They highlighted how a poor financial situation creates this extra burden. This was not the only example where a victim/survivor’s situation or identity resulted in greater impacts from abuse support.

“People with financial stability were able to keep more control of their situation, because they were offered legal advice, and they don’t have to apply for Legal Aid.” – Professional

“… one of the big issues about getting me rehoused was, I did not want to be housed outside my GP’s catchment area.” – Victim/survivor

This victim/survivor highlighted that the support they were being provided to reduce the domestic abuse might also result in the loss of “funding for things that you rely on to survive, or to do basic daily activities”. They emphasised that these impacts from support were “very specific to the disability and to the services” and because of this, “nobody considers” these consequences. This presents as a “a huge barrier to leaving, in lots of ways that nobody expects”. To mitigate for these impacts of support, this victim/survivor had to take on the burden of creating their own bespoke solution. These extra steps to mitigate the side-effects of support increased the length of abuse. Another example was provided by a victim/survivor with complex health conditions looking to get rehoused. The proposed support for the domestic abuse was for the victim/survivor to be put into a shelter, however, this would affect their health condition and could lead to further harm. Interviewees also explained the side-effects and burdens of experiencing domestic abuse while being an immigrant, such as the barriers in place for immigrant mothers with estranged British partners.

“if you’re an abuse victim of a partner that you met here in the UK, there’s no way for you to get access to public funds, unless you have a child with you from your partner, who will be acknowledged sometimes it is difficult as well, because some… some partner in a relationship doesn’t want to acknowledge your child, so it will be depending on your citizen… if you’re Filipino, your child would be Filipino! So, you are Filipino, the child is Filipino, so there’s no way that they would access public funds, unless the child being acknowledged by the father, become a British citizen, then you have your option” – Professional

Another professional outlined the difficulties in seeking support if the victim/survivor is a skilled-worker immigrant with visa sponsorship from a company.

"So, their visa is a skilled worker, and there's no route for them to be helped if their partner has abused them, because their visa is sponsored by the company that they are working with." – Professional

One professional highlighted the complex decisions needed when immigrants seek domestic abuse support and the potential negative impacts, including administrative and financial burdens and impacts on citizenship timescales.

"[She] can change the immigration to a parental visa, but the citizenship will take longer for 10 years. If she's under the skilled worker visa, for now, in the policy of immigration, in 5 years she can be a British citizen, but if she's swapped to parental visa, all the years that she stayed in the UK will be dissolved, and she will start from scratch, and it will take 10 years for her to be a British citizen." – Professional

Victim/survivors highlighted that these extra burdens are often not considered by those in support roles, requiring lived-experience or a victim-voice to understand. This was repeated by a professional who said services couldn't apply their experiences to the victim/survivor's situation

"You have to kind of really contextualise it and say, 'Well, if you had to drop everything – right now – and I told you you couldn't take your two dogs' and they'd say, 'Oh no! I wouldn't be able to do it then', and I'm saying, "Yes, I understand that, but… so why are we putting that onus on victims, and trying to justify that 'the abuse can't be that bad, if you're not willing to leave your house and leave your pets'? At what point have you become so desensitised that these… you think these are reasonable requirements?" – Professional

This leaves victim/survivors having to educate the professionals supporting them or having to influence professionals to relate to their situation. This challenge was echoed by another victim/survivor who explained their support "didn't have the tools about hate crime; about racism; about safeguarding people". One victim/survivor explained that the negative side-effects of support seeking are compounded by the number of marginalised identities one has.

"So this entire time, I have had to constantly educate services that I'm relying on about my disabilities and about how really basic stuff in my world works." – Professional

"You know that if you're not being misunderstood about one aspect of your identity and how that relates to abuse, you're being misunderstood on another" – Victim/survivor

Some interviewees underscored the burdens put onto the victim/survivor by comparing them to the lack of changes forced on the perpetrator of the abuse.

"They [the abusers] don't have to jump through as many hoops as the people trying to get support." – Professional

A Cycle of Being Marginalised

The victim/survivors interviewed described the impacts of the domestic abuse they experienced. Alongside isolation, estrangement from children and knock-on impacts caused by insufficient support, they described suicidal ideation; their children suffering chronic conditions; long-term mental health issues; physical injuries; and unemployment. One victim/survivor explained that the domestic abuse they experienced will affect them "forever". These impacts can cause the victim/survivor with marginalised identities to be marginalised further, particularly intersectionality. Examples were provided around health conditions developing, job loss, and being made homeless because of the abuse.

"It will have an impact until… like the end of my life; I just have to learn to live with this, now. Like, because I will not recover – I will not recover from this – I just have to learn with this, but yeah, it's… it's like a scar." – Victim/survivor

"There's no way that she could pay the rent, because she's taking care of the child, and she cannot afford childcare with the minimum payment that she gets for maternity pay; it's a really difficult situation for her." – Professional

As well as being pigeonholed into their marginalised identities as explained in Section 3, considered exclusively as *what* they are, not *who* they are, one professional highlighted that victim/survivor's may have their identity reduced to their abuse.

"I think that people that have been victims of abuse will always be known as a 'victim of abuse'." – Professional

Theme 5: Weaponising Identities

> *"The things that they've struggled with are then used to blame them." – Professional*

Victim/survivors' identity may be used directly within the abuse itself. This, the *weaponisation of identity*, was described by many interviewees and was seen as a tactic used by abusers and as a transgression committed by services.

Weaponisation of Identity by Perpetrators

The victim/survivors we interviewed discussed the way in which perpetrators utilised identity against them as part of the abuse. One victim/survivor explained the coercive control endured due to their disability and gender.

"I think being controlled; having every aspect of my life under constant control; being told that because I'm blind, and a woman, I couldn't have high aspirations or be independent." – Victim/survivor

This co-opting of marginalised identities also occurs when perpetrators use the emergence of transitional identities to begin or intensify their abuse. For instance, pregnancy was commonly described as a trigger for abuse starting or escalating. Two interviewees attributed pregnancy to the start of the abuse with another implicitly linking pregnancy to further hostile behaviour. In a similar way, another victim/survivor identified the abuse they experienced worsened due to difficulties with her health.

"[The abuse started] when I got pregnant with my daughter." – Victim/survivor

"as my health got worse, things intensified with him." – Victim/survivor

Some victim/survivors expressed concern that the abuser might exploit misunderstandings about their identity to manipulate services as part of the abuse.

"One of my biggest worries back then was that because I already had mental health issues, I was very afraid that he would, like, try to get me sectioned or something." - Victim/survivor

Weaponisation of Identity by Services

Not only did victim/survivors explain how perpetrators weaponise identity, but many also described how some support services do as well. Many of the victim/survivors highlighted the need to present in a certain way when interacting with services. Collectively, the experiences of the victim/survivors interviewed delineated the boundaries of what services implicitly deem *an acceptable victim*. One victim/survivor described their experience of services responding to their disclosure of sexual abuse. Their response, they explained, was influenced by the fact they had a health condition describing that "I was blamed for… for the rapes."

Another victim/survivor talked of their learnt composure to be taken seriously as a young woman. Others described services being dismissive if victim/survivors were seen as lacking composure and being too emotional. Whilst others explained that services may minimise their trauma if they appear too composed, describing an unhelpful response from the police because they appeared too calm.

"When you are female and young … you're not taken seriously. So, I'd learned as a child that I had to be, essentially, a 'professional patient'. I had learned to be calm, and polite, and analytical, and to talk about really dark things without showing emotion." – Victim/survivor

This experience was not unique. Another victim/survivor explained the barriers they faced in getting support because they werre not deemed emotive enough.

"That particular social worker… she couldn't believe in my emotions unless I performed them" – Victim/survivor

"...the police officer … was like, 'Oh, you just look hysterical' like, you know, 'Put yourself together' and just like… you know. So, these words stayed with me, and I was like, 'Ok, I have to look composed when I say that', but it was so hard, like, I… it was really hard, like, to stay calm and composed while saying that something went really wrong" – Victim/survivor

The expectation of a *typical victim/survivor* does not only cover the emotional response to domestic abuse but also the physical impacts. One victim/survivor explained that ethnicity was used to minimise the physical signs of domestic abuse, describing that GP's and police lacked understanding of the full extent of injuries due to the colour of their skin not showing the signs of bruising. Minimising of abuse was described in a separate interview, explaining that judicial support was unavailable to them as they were perceived as having *too many* physical signs of trauma due to a health condition.

"I have [health condition], and … once the sexual abuse was disclosed, I was told that the bleeding and the bruising I experienced after the rapes … were due to my [health condition]. That led the CPS to not accept the case in court." – Victim/survivor

When victim/survivors didn't respond in a *suitable* way, interviewees explained how they were scared services would dismiss them as "crazy". This fear was borne out of lived experience for one victim/survivor who was assumed to be mentally ill by police when they didn't press charges against their abuser and feeling that this played into the narrative of the abusive partner. One victim/survivor also described their ethnicity as a barrier to receiving long-term support.

"I felt like if I disclose this and I cry, then it will be seen as like… oh, I'm like the crazy woman" – Victim/survivor

"[the police officer] was like, 'because anyone who's rational would press charges, so are you sure you don't have any mental health problems?' and I'm like, 'No, I don't! I don't!' I was like, 'I'm just… I don't want to press charges" – Victim/survivor

Hiding Identities

The negative impact of having intersecting identities leads some victim/survivors to hiding or supressing their identity for fear it will compound the trauma caused by the domestic abuse. Interviewees described a guardedness to disclosing identity to professionals including only trusting one professional to know their gender identity and hiding their sexuality from their support. Identity was also hidden from abusers, victim/survivors described how revealing further parts of their identity "would make things worse". One professional highlighted that by having to hide one's identity, this gives the abuser more power, for example a perpetrator using the threat of "outing" the victim/survivor. One victim/survivor likened their identity to a "timebomb".

"… I've always found though, that LGBTQ+ just have a… there's a stigma around approaching, and… if there's a cultural aspect, where 'I don't want my partner to [out] me; I don't want my family to find out'…" – Professional

Theme 6: A Single Point of Light

"Like she went to the police with me; she organised the police interview, I mean, it was really good, and she was brilliant, and… she referred me to psychological support… I mean, that was… perfect" – Victim/survivor

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Against this backdrop of barriers, unmet needs, and exploitation of identity, many victim/survivors explained the positive effect of a specific individual (or organisation) within their route to safety. Describing individual professionals as "the person that helped … the most in this entire thing". Victim/survivors often identified a named professional who provided broader, needs-based support ranging from logistical to emotional. Many interviewees believe this support was essential in getting help, but some highlighted the shortcomings in relying on one person.

Individuals Within the System

During the interviews, victim/survivors were keen to highlight the individuals in professional roles who were singly there for them. One repeated characteristic of these individuals was that they believed the

victim/survivor during disclosure. Victim/survivors highlighted the impact of being believed and one emphasised the significance of a professional proactively giving them time and space to talk through their experiences.

"I did have a rehab officer from the Council, and she was very helpful. Yeah, she… she believed me, and took me seriously." – Victim/survivor

"I mean, the doctor was amazing; he was really good, and then he started everything" – Victim/survivor

"The counsellor that I saw saved my life" – Victim/survivor

During their interviews, professionals were also aware of their role as trusted individuals within an untrusted system. Some professionals were also keen to highlight other professionals who they repeatedly rely on, whether it was this "one solicitor" or this "specific lawyer".

"One woman said – I did not interview them, but I'm their case worker – it's my colleague who interviewed them, and they mentioned that '{Name} make me feel that there is hope'" – Professional

Logistical Support

As well as the importance a professional's initial response to a disclosure, victim/survivors explained the logistical help that can be provided when professionals are proactive. Professionals were keen to explain the specific, concrete steps that they could take to support the victim/survivor. Many of these steps involved providing "very important details that they [the victim/survivors] need to know". They explained the impact they had when "guiding somebody through the process". These logistical steps are varied and relate to the specific needs of individuals and could relate to immigration, finances, legislation, privacy or caring responsibilities.

"I think it's called {Service}; they were the ones who actually helped me to get an emergency non-molestation order. Yeah, they were the ones who helped me to get that – immediately – which was really helpful." – Victim/survivor

"I explain what the concession entails, like once you get the 3-months MVDA – Migrants, Victims Domestic Abuse concession visa, you will be able to access public funds." – Professional

"if they have children, they don't want to move – so, things like getting a doorbell, changing phone number, and putting some orders in place to make sure the perpetrator does not gain contact with this person." – Professional

"I was helping with debt management and, like, communications, and directing people to the people that they had to see – the correct people – so they didn't have to wait around and ...you know... skip the long wait and everything, by being passed from pillar to post; it was find out what their problem was, who they needed to speak to, and direct them in the right way." – Professional

One professional explained how their service provided concrete steps for support regardless of the victim/survivor's risk score. They explained their service worked alongside the risk assessment, irrespective of severity, to provide more bespoke care.

"with people who are deemed at kind of medium/standard risk, or historic abuse, we work like a pathway of support with them, so it's more kind of cognitive and trying to understand what they've been through; what the impacts of that form of abuse are – particularly kind of the long-term like mental health impact – and then helping with coping strategies and grounding techniques, stuff like that." – Professional

Emotional Support

As well as the logistical support, victim/survivors may need a more holistic, emotional support system in place. As one victim/support explained "you just want to be held a little bit". One professional highlighted the impact of this emotional support, using the example of Black and racially minoritised victim/survivors within the army.

"The ethnic minorities that do follow through, interestingly enough, are the ones who are based on army camps, which is interesting. There is a lot of support for army families, even from ethnic minorities, like Gurkha communities, all that kind of thing, which is just not prevalent in the rest of society. So actually, there's 3 cases at the minute that are going through the Courts down here, and all 2 of them are from

army ethnic minority families. But they have massive support from the army bases, which is very nice; it's very encouraging." – Professional

Professionals also highlighted the importance of providing this emotional support in a suitable environment using an accessible method, and the importance of victim/survivors feeling listened to.

"Work with someone, empower them, help them to understand that they are a victim" – Professional

"I used to go to meet him in the Social Club, because it was the only place he felt comfortable" – Professional

"Someone who is deaf, they're not going to be able to just pick up the phone and have a chat; you need to make it work with them" – Professional

This emotional support is also given to minimise the burdens put on the victim/survivor. Professionals explained how they try to move away from siloed services, where the victim/survivor is the go-between to "a joint collaborative between us as the allocated worker, and the victim/survivor themselves". Minimising burdens can be small measures like raising issues to the council or helping to fill in a form. One victim/survivor explained that their social worker came to every meeting with them to improve the consistency of their experience, whilst another explained that their support group do weekly check-ins. Professionals may also exceed their service's usual remit to help with consistency of care.

"if she is answering a form, I will also be there to guide her to answer the form." – Professional

"I mediate, and explain further, and advocate for the victim, because… I always believe the disclosure that they made" – Professional

"So, our team … we hold people for the immediate risk time, so holding onto clients long-term is not normal. I've held onto one client recently – I've had her for a year – only because it was a really serious sexual offence, this one, and it's going to court, and we don't want to… we don't want to lose her! We don't want her to disengage" – Professional

Many professionals highlighted how their previous lived-experienced provided a guide for their interaction with victim/survivors. Some professionals identified that their own lived experience was able to help them provide better care and have greater empathy for victim/survivors, with one describing that they were providing training for autism to improve the route to safety they experienced. The use of lived experience or a shared knowledge by professionals was highlighted as a positive by victim/survivors, including one who felt relief at a shared understanding of autism. This parallels the sentiments expressed in Section 1, where a sense of shared identity was pivotal to successful improvised reporting pathways.

The Burden of Support

Victim/survivors explained the positive impact a single professional can have. However, they also hinted at the downside: these isolated pockets of good practice are dependent on one person. This person therefore becomes the single point of failure. This can lead to a sudden lack of support if that person is off sick or quits, and this responsibility can be emotionally demanding for the professional.

"it's Easter holidays, so my therapist and social worker are both off, and there's nobody else to talk to." – Victim/survivor

Discussion

The literature, quantitative data, and interviews with victim/survivors and professionals, evidence differences in the ways domestic abuse is experienced by different identities and that identity influences every aspect of domestic abuse; from the ways the abuse is perpetrated to the effectiveness and accessibility of long-term support.

How do referral pathways and length of abuse differ by intersecting identities?

Our data shows differences in referral routes by identity. This can be aligned to the services that they are likely to be more visible to. For example, young people are significantly more likely to be referred through children's social care and through educational institutions which are where we would expect young people to be; more likely to disclose violence; and their experiences of abuse are more likely to be recognised. The same can be said for the increased proportion of referrals through healthcare settings for older victim/survivors and for disabled victim/survivors.

Our quantitative analysis also identified significantly lower proportion of referrals are made by the police for victim/survivors who are Black and racially minoritised (22.1% compared to 28.6%, see Table A2). The same underrepresentation in police referrals is found when considering those victim/survivors with a disability compared to those without (19.8% compared to 29.0%, see Table A3). Both these communities have a higher rate of helpline referrals. Black and racially minoritised victim/survivors are referred through helplines in 17.6% of cases compared to 4.0% for White victim/survivors (See Table A3) The same disparity is found for disabled victim/survivors (10.2% compared to 5.3%, see Table A3) Interviews with victim/survivors and professionals also highlighted the use of social media platforms and community groups by these marginalised demographics.

The quantitative analysis also identified differences for disabled black and racially minoritised victim/survivors and greater referral via helpline and fewer through police. Literature and our interviews suggest reasons for underrepresentation of certain identities through statutory routes to safety; firstly systemic, societal-level inequalities and the normalisation of prejudice tied to identity, prevents certain victim/survivors being recognised by services (Wydall et al's, 2023); secondly, some marginalised communities have developed a distrust of authorities, which reduces the likelihood of reporting abuse through official channels (Evans & Feder, 2014; Dixton et al, 2022). This can mean that marginalised individuals or their communities being let down by services in multiple contexts (Evans & Feder, 2014; Idriss, 2020).

However, the latest quarterly MARAC data (SafeLives, 2025) shows that nearly two thirds of cases are referred through the police. The limited representation of certain communities within police referrals is likely to result in underrepresentation at MARAC which is seen for Black, Asian and racially minoritised victim/survivors, as well as LGBT+ and disabled victim/survivors.

The quantitative data suggests that victim/survivors from marginalized communities use alternative disclosure and referral routes such as helplines and self-referrals. The interviews highlighted that victim/survivors with marginalised identities may have a greater trust in by-and-for organisations due to a shared identity or lived experience. These organisations play a vital role and the support they provide has been commended within our interviews.

Literature suggests having limited access to (or not wanting to use) statutory disclosure and referral routes may be one reason Black and ethnically minoritised and disabled victim/survivors have a longer period of abuse (Evans & Feder, 2014; Heron, 2022). Quantitative analysis highlights the significantly increased lengths of abuse for individuals from these communities. Our research identified experiences of disclosures not being believed and experiences minimised. Our interviews described feeling more comfortable with 'by and for' organisations who validate their experiences of abuse; however, these organisations may have less funding and a more limited scope.

For some marginalised communities length of abuse is increased which could be due to abuse being minimised or normalised (Tsegay & Tecleberhan, 2023). Literature highlighted that victim/survivors could have their experiences disregarded due to systemic prejudice and differential visibility. Interviews

highlighted there are missed opportunities to identify abuse and responses to disclosures can be negative and unhelpful. The interviewees discussed minimisation of their experiences following disclosure; multiple visits to services where they had clear signs of abuse; and having to make multiple disclosures. Interviews with professionals highlighted that victim/survivors can begin to minimise and normalize the abuse which can prolong the length of the abuse.

Experiences of isolation were explored withing the research and can be experienced before domestic abuse starts. Interviews identified that alongside formal disclosure and referral routes, friends, family and local community provide an essential support network for victim/survivors of domestic abuse in identifying signs of abuse and receiving disclosures. However, many victim/survivors interviewed talked of their isolation due to age, disability, or immigration status. This isolation is echoed in the literature (Alderson et al, 2022; Bates & Carthy, 2020). The base-level isolation can be compounded by the perpetrator as part of coercive control and domestic abuse (Bates & Carthy 2020; Mulvihill et al, 2023). Further research could explore if increased isolation was linked to the increase in length of abuse seen for victim/survivors over 50 in the quantitative analysis.

How does risk profile differ by intersecting identities?

One of the ways risk is measured is through the number of ticks on the DASH. The quantitative data measures this at intake and at exit. Our analysis identified a significantly higher number of ticks on the DASH at intake for victim/survivors who have a disability, LGBT+, female or identify their gender in another way.

Our analysis identifies that the number of ticks decrease with age, with victim/survivors aged 51 and over having a lower number of ticks at intake and those aged 19-35 having a higher number of ticks. This negative correlation with risk and age should be caveated: it is important to note that some questions on the DASH may not be relevant for older individuals, and this could skew the numbers. Specifically, two questions from the DASH risk assessment may not be relevant for older individuals, meaning that there are 22 possible ticks instead of 24. These two questions involve child contact and pregnancy.

Our interviews identified a learnt distrust of services meant that victim/survivors from marginalised communities usually seek help and disclose domestic abuse when it escalates to the point of crisis. This point of crisis is likely to be when domestic abuse escalates or involves physical violence, which could impact on the number of ticks on the DASH. Interviews highlighted that LGBT+ communities specifically are often hesitant to contact the police or other authorities until a critical juncture in abuse.

Our interviews' suggested authorities were more reticent to identify domestic abuse against marginalised communities when the abuse was non-physical. Interviewees described that unhelpful responses to disclosures from services meant abuse could escalate and multiple disclosures might need to happen before it was acted upon. Examples were also given in the interviews of isolation meaning that there are fewer people within the victim/survivor's network to recognise early signs of domestic abuse. Interviews described perpetrators using isolation as part of the abuse and using changes in identity such as immigration status or pregnancy to trigger abuse or escalate abuse which could impact on risk.

Interviews identified that some communities are small and interconnected which could increase risk when help-seeking and the support networks may include the perpetrator. Victim/survivors explained that perpetrators can manipulate their community as part of the abuse with attempts to disclose abuse or seek help could be relayed back to the perpetrator and this breach of confidentiality can significantly increase the risk to the victim/survivor. This may lead to prolonged experiences of abuse and delay help-seeking until the point of crisis due to fear of disclosure.

When we apply the intersectional lens through our analysis, we see that intersectional identity has a compounding effect where the number of ticks at intake is significantly different than would be expected from the individual identities on their own.

The quantitative analysis identifies differences in the change in risk profile from when a victim/survivor entered a service to when they exited the services with some identities having a greater reduction in

risk and some having a lower reduction in risk. Further research is needed to understand the differences considering the level of risk at intake compared to exit. However, when we compare the intersection of identities, we can see that ethnicity and disability have a significant interaction. Specifically, the combination of being both Black, African, Caribbean, or Black British and having a disability is associated with a smaller reduction in risk from intake to exit compared to White victim/survivors who had a disability. Further research could explore the differences in risk reduction by identity.

Professionals identified the importance of support services considering each victim/survivor's specific circumstances and needs to provide effective and appropriate support to minimise risk, during and after the abuse.

How do victim/survivors' needs differ by intersecting identities?

The quantitative analysis and interviews identified that needs of victim/survivors differ across identities with a higher number of needs identified at intake for marginalised communities across ethnicity, sexuality, and disability. Interviews identified gaps and barriers to needs being met, especially when these were complex or overlapping and described services not being available, accessible or appropriate. Our interviews also identified the challenges of this within a domestic abuse setting where organisations may have a specific focus which may not be able to meet the multiple and overlapping needs.

The quantitative analysis identified differences in the types of domestic abuse being experienced by different identities. For example, physical abuse, sexual abuse, harassment and stalking and jealous and controlling behaviour decreases with age. Higher levels of physical abuse were also reported by White victim/survivors and specific intersections of identity were also identified as experiencing different levels of physical abuse. This was particularly true around sexuality and age: some of the non-heterosexual younger age groups experienced lower levels of physical abuse compared to heterosexual women of the same age. For female victim/survivors aged 51+ and Asian / Asian British the severity of harassment and stalking is higher. These differences in abuse being experienced will impact on the type of support needed. Our interviews identified that some forms of domestic abuse may not be identified or supported as well as others which could further impact on specific marginalised identities.

Our interviews identified that generic domestic abuse services (and wider services) may not be accessible or appropriate for victim/survivors from marginalised communities as they are designed for a perceived 'norm'. Professionals and literature discussed the needs of individuals that were not always able to be met when catering to this stereotype (Desai et al, 2024). Examples were given in interviews where support wasn't available due to accessibility including, the lack of foreign language translators, neurodiverse communication styles, the use of unhelpful physical spaces, and the impacts of caring responsibilities. Interviews outlined that support put in place by services can be unhelpful and not meet all the needs, and in order to meet one of the needs victim/survivors might need to make difficult choices which could impact on other needs in relation to their identity. For example, support could cause complexities with different visas, it could impact on access to funding, access to healthcare, and an inability to work (Alderson et al, 2022). The examples given were services not being able to see all the potential impacts (including negative ones) but not supporting the whole person.

Some of the interviews discussed the complex, multiple needs that impact on the support that is received. Specialist services may not be aware of how to support all the victim/survivor's needs which could lead to having to choose which of their identities has the highest need at that time. Professionals discussed how each service typically provides training for their specific focus but there is a gap in intersectionality training.

Interviews outlined siloed delivery of services and victim/survivors needing to engage with multiple agencies to support their various needs. They went onto describe that this can be overwhelming and create additional barriers to accessing effective support. One professional noted that they intentionally refer clients to specific services with which they have established relationships, as this increases the likelihood that the victim/survivor will receive appropriate and responsive care across services. When

professionals are not proactive at referring victim/survivors they may receive support from unsuitable or ill-fitting services. Victim/survivors described their needs not being met and disengagement from support. Our interviews outlined the value that was placed on 'by and for' organisations where lived experience of both domestic abuse and different marginalized identities was felt to create a shared understanding and have a positive impact in building trust and in being able to support the needs and identify gaps and challenges in generic risk, safety and support plans.

This research found that individuals may not always recognise their own marginalised identity, or this may be invisible to the services from whom they are seeking help. Literature explored that identities can be differentially visible to the individual themselves, often being mentioned around disability (Bradbury-Jones et al, 2015). This was seen in our interviews where some victim/survivors were not aware of some of their marginalized identities at the time of the abuse such as neurodivergence, sexual orientation, and gender identity.

External validation was a theme in both the literature and our interviews. This was discussed to counteract minimisation and normalisation of abuse and to recognise abuse earlier, before it escalates to high risk, victim/survivors discussed the impact of third-party validation in recognising abuse. Both victim/survivors and professionals emphasised that being validated and believed is a critical aspect of initial engagement after disclosure, building trust and encouraging further disclosure. Victim/survivors highlighted the importance of a professional proactively giving them time and space to talk through their experiences. Some discussed that this validation can be more impactful when it comes from statutory services such as the police.

How do outcomes differ by intersecting victim/survivor identity?

There are differences in outcomes by identity following support. The quantitative analysis found that individuals aged 19–35 reported higher feelings of safety and greater improvements in quality of life after receiving support compared to younger or older victim/survivors. Asian / Asian British victim/survivors also reported higher perceptions of safety, wellbeing, and quality of life following support. Conversely, disabled victim/survivors, particularly disabled Black and Black British individuals, reported lower perceived improvements in wellbeing and quality of life.

The interviews explored the impacts of domestic abuse which can be long-lasting and extensive. The interviews outlined examples of the abuse leading to additional needs such as financial difficulties, mental health conditions, deteriorations in physical health, and immigration issues. Domestic abuse can also lead to additional marginalisation, such as physical or mental health conditions, homelessness, or unemployment.

The quantitative analysis is focused on individuals receiving support from domestic abuse services. However, the interviews explore the some of the challenges and reasons why outcomes may differ, including delays in support being received and the type of support not being appropriate. Victim/survivors described disclosures of abuse being met with unhelpful or dismissive responses from services or their support networks, including friends and family, which can delay further disclosures.

Our interviews described the positive outcomes when effective support is received and the high regard, they held support services in. Our interviews described the impact of the support on their long-term outcomes.

Areas for additional research

- Additional analysis and research into the risk level identified and the types of abuse being experienced.
- Additional research into intersectionality and the risk-care pathway, including the risk assessments being used and feeding into any reviews of multi-agency tools and pathways.
- Additional research working with helplines and services aligned with the needs of different marginalised identities to understand the volume of cases and explore future opportunities.
- Expand the interviews and research into younger age groups through analysis of the children and young people Insights data and qualitative research.
- Expand the research to include those causing harm.

- Additional analysis of the Insights dataset to include analysis on the types of abuse and relative level at intake and changes in level of abuse and the age and length of abuse as a proportion of dating life to explore between groups
- An exploration of possible improvements to information sharing across services including a unified information sharing across services.
- Additional analysis and exploration of mental health needs of different cohorts identified within the research such as bisexual, lesbian, and gay victim/survivors

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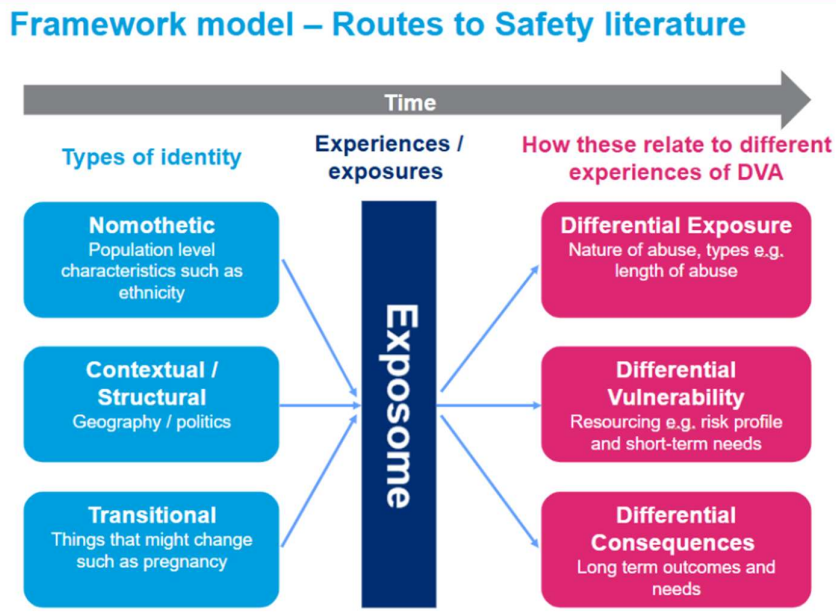
Appendices

Appendix 1: Research framework and variables

Literature review framework model applied



Dependent variables / Experiences of abuse

Dependent variables	
Descriptive statistics only	
Referral route	Referral route was treated as a categorical variable, with one of 23 distinct referral pathways. This included: police, Multi-Agency Risk Assessment Conference (MARAC), self-referral, health, hospital, community health, mental health, housing, drug and alcohol, education, children's social services, adult social services, probation, CRC, domestic violence and sexual violence (DVA & SV) services, helpline, specialist services, Multi-Agency Safeguarding Hub (MASH), domestic violence court, and 'other' category for all remaining referral types.
Needs at intake	Ten distinct need areas were assessed: alcohol misuse; children and parenting; drug misuse; employment, education and training; finance, benefits and debt; housing; immigration; mental health; physical health; and social and community support. Each need was recorded as a binary variable, indicating whether a need was identified.
Included in the statistical analysis	
Length of abuse	Treated as a continuous variable, representing the number of months a victim/survivor experienced abuse prior to referral.

Risk profile • **Intake** • **Change**	*Intake* - the number of ticks recorded on the Domestic Abuse, Stalking and Honour-Based Violence Risk Identification Checklist (DASH RIC) at the point of intake. This variable served as an indicator of the initial level of risk and was treated as continuous variable in the multilevel models. Scores ranged from 1 to 24, with higher values indicating greater risk *Change* - calculated by subtracting the number of DASH RIC ticks at exit from the number recorded at intake. This produced a continuous variable representing the direction and magnitude of change in risk from intake to exit. Positive values indicated a reduction in risk, negative values indicated an increase, and zero reflected no change. Observed values ranged from -16 to 20.
Level of abuse – intake • **Physical** • **Sexual** • **Harassment and stalking** • **Jealous and controlling behaviour**	These variables were treated as continuous variables and ranged from 1 to 4, with higher values indicating greater severity. A score of one indicates that the abuse was not present, two indicates a standard level of abuse, three indicates a moderate level, and four indicates a high level of that type of abuse.
Level of abuse – change • **Physical** • **Sexual** • **Harassment and stalking** • **Jealous and controlling behaviour**	These variables were calculated by subtracting the level of the type of abuse recorded at exit from the level of the type of abuse recorded at intake. The variables were treated as continuous and ranged from -3 to 3. Positive values indicate a reduction in the level of abuse, negative values indicate an increase, and a value of zero reflects no change.
Client reported outcomes • **Perceived safety** • **Perceived wellbeing** • **Perceived quality of life**	At the point of exit, clients were asked to indicate their level of agreement with the statements “I feel safer.”, “My wellbeing has improved.”, and “My quality of life has improved.” Responses were recorded on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). This variable was treated as continuous in the analysis, with higher scores indicating a greater perceived sense of safety / wellbeing / quality of life.

Independent variables

Five demographic characteristics were included as fixed effects in the multilevel models to assess their influence on the dependent variables described above. In addition, the year in which the client was referred to the service was included as a fixed effect. The service provider was included as a random effect to account for clustering. To further explore the influence of intersectional identities on the outcome variables, a second model was estimated that introduced an additional random effect for identity strata.

Independent variables	
Identity variables (Fixed effects)	
Gender identity	Collected from victim/survivors using three categories: • Male • Female • In another way. All three categories were included in the descriptive analysis of the dependent variables. However, for the multilevel model analyses, the 'in another way' category was excluded because there were too few cases to support meaningful statistical analysis
Sexuality	Collected from victim/survivors using five categories: • Heterosexual • Bisexual • Gay • Lesbian • Other. All five categories were included in the descriptive analysis of the dependent variables. However, for the multilevel model analyses, the 'other' category was excluded because there were too few cases to support meaningful statistical analysis.
Age	Categorized into four groups • 18 years old and under • 19–35 years, • 36–50 years, • 51 years older and over. All four categories were included in the descriptive analysis of the dependent variables as well as in the multilevel model analyses.
Ethnicity	Collected from victim/survivors using five categories: • White • Mixed/Multiple ethnic groups • Asian/Asian British • Black/African/Caribbean/Black British • Other ethnic group. All five categories were included in the descriptive analysis of the dependent variables as well as in the multilevel model analyses.
Disability status	Recorded as victim/survivors: • Having a disability • Not having a disability. This variable was included in both the descriptive analysis of the dependent variables and the multilevel model analyses.
Year case opened	Included in the multilevel models as a control variable and was centred around 2020, the median year in the dataset.
Random effects (grouping variables)	

Service provider	To account for clustering the service was included as a random effect in the multilevel model analyses. This approach controlled for unobserved variation across services that could influence outcomes, ensuring more accurate estimation of fixed effects.
Identity strata	This is defined by unique combinations of five identity variables (age, gender, ethnicity, sexuality, disability). This was included as a random effect in the multilevel models conducted as part of the intersectional identity analyses to explore the interaction of an individual's multiple identities and outcome variables.

Interview expression of interest breakdown

Interview recruitment Details	Victim/Survivors	Professionals
Expression of Interest Forms Completed	9	28
Additional interest outside expression of interest form	1 (via services) 4 (from professionals EOI)	1 (contacted directly)
Not proceeding	3 (contact details not provided)	5 (contact details not provided) 1 (duplicate on victim/survivor EOI) 4 (identified as victim/survivor) 1 (duplicate organisation)
Information Sheets and Consent Forms sent	11	18
Information Sheets and Consent Forms Completed	11	12
Number of People Interviewed	7	6

Appendix 2: Analysis charts and graphs

Table A1: The average number of needs identified for each demographic out of the ten needs groups present in the quantitative data.

	Average Number of Needs Identified /10
Gender	
Female	2.32
Male	2.09
In another way	3.10
Age	
18 years and under	2.08
19 – 35 years old	2.33
36 – 50 years old	2.36
51 years and older	2.07
Ethnicity	
White	2.23
Asian / Asian British	2.88
Black / African / Caribbean / Black British	3.09
Mixed / Multiple ethnic groups	2.52
Other ethnic group	3.75
Sexuality	
Heterosexual	2.29
Bisexual	3.22
Gay	2.40
Lesbian	2.65
Other	4.08
Disability	
Disability	3.08
No disability	2.17

Table A2: The percentages of victim/survivors being referred through the Police and Helplines by Ethnicity.

Ethnicity	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group	All Black and racially minoritised
Police	28.6% (7465)	14.6% (284)	13.7% (80)	22.8% (121)	20.7% (56)	22.1% (1045)
Helplines	4.0% (1044)	25.9% (503)	19.4% (113)	14.9% (79)	11.1% (30)	17.6% (832)

Table A3: The percentages of victim/survivors being referred through the police and helplines by Disability Status.

Disability	No	Yes
Police	29.0% (7583)	19.8% (927)
Helplines	5.3% (1397)	10.2% (479)

Table A4: Predicted Duration of Abuse (in Months) by Ethnicity and Age.

Age Group	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
18 and under	19.53 (11.46, 27.61) *n=628*	77.30 (53.80, 100.81) *n=42*	*n=6**	25.45 (-5.53, 56.43) *n=23*	*n=6**
19–35	38.38	48.19	46.88	39.73	49.88

	(32.69, 44.07) *n=14486*	(40.83, 55.54) *n=900*	(36.39, 57.36) *n=267*	(29.86, 49.60) *n=321*	(35.82, 63.95) *n=130*
36–50	70.02 (64.23, 75.80) *n=8307*	99.06 (91.40, 106.73) *n=766*	88.61 (77.69, 99.53) *n=241*	73.14 (59.96, 86.33) *n=151*	74.56 (59.16, 89.96) *n=106*
51+	117.37 (111.10, 123.64) *n=2687*	153.73 (140.25, 167.21) *n=142*	87.17 (61.84, 112.50) *n=35*	155.84 (119.95, 191.73) *n=17*	96.95 (61.07, 132.83) *n=17*

*Values represent months of abuse with 95% confidence intervals in parentheses. *indicates the sample size is low and is therefore not represented within the corresponding graph.*

Table A5: Predicted Duration of Abuse (in Months) by Ethnicity and Disability Status. Values represent months of abuse with 95% confidence intervals in parentheses.

Disability	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group
No disability	70.67 (64.87, 76.47) *n=22,239*	89.82 (83.08, 96.56) *n=1,588*	82.18 (73.40, 90.96) *n=469*	74.47 (65.38, 83.56) *n=429*	77.52 (66.10, 88.93) *n=220*
Disability	74.18 (68.02, 80.35) *n=3,869*	105.58 (94.89, 116.27) *n=262*	77.49 (60.06, 94.93) *n=80*	75.16 (57.92, 92.39) *n=83*	89.16 (64.39, 113.92) *n=39*

Table A6: Predicted Level of Sexual Abuse at Intake by Ethnicity and Sexuality.

Sexuality	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple Ethnic Groups	Other Ethnic Group
Heterosexual	1.54 (1.43, 1.65) n = 25505	1.64 (1.52, 1.75) n = 1817	1.67 (1.53, 1.80) n = 526	1.51 (1.37, 1.65) n = 493	1.72 (1.56, 1.88) n = 249
Bisexual	1.67 (1.53, 1.82) n = 377	1.45 (1.02, 1.88) n = 23	1.92 (1.44, 2.40) n = 18	1.65 (1.09, 2.21) n = 13	n = 3*
Gay	1.49 (0.99, 1.99) n = 19	n = 0	n = 0	n = 0	n = 0
Lesbian	1.57 (1.39, 1.75) n = 193	n = 6*	n = 2*	n = 2*	n = 3*

*Values represent months of abuse with 95% confidence intervals in parentheses. *indicates the sample size is low*

Appendix 3: Needs and Referral Routes

Table A7: The count and % of needs identified per demographic Group

Independent variable	Alcohol misuse		Children and parenting		Drug misuse		Employment, education, and training		Finance, benefits, and debt		Housing		Immigration		Mental health		Physical health		Social and community support	
Gender	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Female	2354	*8.7*	8599	*31.3*	1936	*7.1*	3749	*13.8*	8200	*30.3*	13435	*48.4*	856	*3.1*	14828	*54.2*	4139	*15.2*	9738	*35.8*
Male	139	*10.1*	304	*21.5*	117	*8.3*	198	*14.2*	365	*26.5*	542	*38.5*	44	*3.1*	716	*51.3*	266	*19.0*	431	*31.0*
In another way	7	*17.5*	10	*25.0*	10	*25.0*	9	*23.1*	15	*37.5*	24	*58.5*	1	*2.6*	21	*52.5*	14	*34.1*	19	*48.7*
Age																				
18 years and under	25	*3.7*	138	*19.9*	59	*8.6*	197	*28.2*	135	*19.4*	257	*36.4*	6	*0.9*	422	*60.8*	68	*9.8*	247	*35.3*
19 – 35 years old	1106	*7.2*	5561	*35.6*	1289	*8.3*	2297	*14.9*	4548	*29.6*	7971	*50.3*	548	*3.5*	8406	*53.9*	1691	*10.9*	5410	*35.0*
36 – 50 years old	1048	*11.2*	*2976*	*31.3*	647	*6.9*	1242	*13.3*	3045	*32.5*	4477	*46.7*	309	*3.3*	5123	*54.2*	1663	*17.7*	3406	*36.3*
51 years+	321	*10.6*	*238*	*7.7*	68	*2.2*	220	*7.2*	852	*28.1*	1296	*41.9*	38	*1.2*	1614	*53.1*	997	*32.4*	1125	*36.7*
Ethnicity																				
White	2403	*9.5*	7971	*31.0*	1995	*7.8*	3138	*12.3*	7045	*27.8*	11944	*45.8*	195	*0.8*	14063	*54.9*	3824	*15.0*	8768	*34.4*
Asian / Asian British	37	*2.0*	497	*26.8*	22	*1.2*	490	*26.4*	903	*48.8*	1163	*61.9*	393	*21.3*	891	*48.0*	349	*18.7*	846	*45.7*
Black / African / Caribbean / Black British	22	*4.1*	201	*36.2*	13	*2.4*	143	*26.4*	287	*52.7*	386	*70.7*	165	*30.2*	241	*44.4*	98	*18.0*	241	*44.7*
Mixed / Multiple ethnic groups	32	*6.7*	149	*30.5*	28	*5.8*	79	*16.6*	181	*37.6*	327	*66.1*	32	*6.6*	252	*51.4*	72	*14.9*	184	*38.2*
Other ethnic group	6	*2.4*	95	*37.4*	5	*2.0*	106	*41.4*	164	*63.6*	181	*70.4*	116	*45.8*	118	*46.5*	76	*30.2*	149	*58.2*
Sexuality																				
Heterosexuality	2382	*8.6*	8705	*31.0*	1953	*7.0*	3774	*13.6*	8292	*30.0*	13571	*47.8*	857	*3.1*	14982	*53.6*	4211	*15.1*	9823	*35.3*
Bisexual	75	*17.2*	151	*34.3*	69	*15.7*	103	*24.0*	168	*38.5*	245	*54.4*	29	*6.6*	329	*74.8*	111	*25.6*	209	*47.9*
Gay	17	*13.5*	5	*3.8*	13	*10.2*	27	*21.1*	39	*30.2*	59	*45.4*	1	*0.8*	86	*65.2*	31	*24.2*	53	*41.4*
Lesbian	22	*11.8*	41	*21.1*	23	*12.2*	35	*18.2*	64	*33.2*	100	*52.1*	8	*4.1*	137	*69.9*	45	*23.4*	78	*41.3*
Other	4	*10.8*	11	*28.2*	5	*13.2*	17	*42.5*	17	*42.5*	26	*65.0*	6	*15.4*	31	*77.5*	21	*53.8*	25	*64.1*
Disability																				
Disability	520	*12.0*	1136	*25.6*	434	*9.9*	665	*15.3*	1638	*28.8*	2566	*57.4*	92	*2.1*	3309	*74.3*	2044	*46.0*	2014	*46.0*
No disability	1980	*8.2*	7777	*31.8*	1629	*6.7*	3291	*13.6*	6942	*37.6*	11435	*46.2*	809	*3.3*	12256	*50.4*	2375	*9.8*	8174	*33.7*

Independent variable	Adult social services		Childen's social services		Community health		CRC		Domestic violence court		Drug and alcohol		DVA & SV services		Education		Health		Helpline		Hospital	
Gender	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Male	35	2.3	67	4.48	13	0.87	0	0.00	3	0.20	5	0.33	50	3.35	9	0.60	38	2.54	78	5.22	31	2.07
Female	316	1.1	2723	9.30	247	0.84	10	0.03	28	0.10	83	0.28	1825	6.23	166	0.57	526	1.80	1796	6.13	455	1.55
In another way	0	0.0	4	9.52	2	4.76	0	0.00	0	0.00	0	0.00	1	2.38	2	4.76	0	0.00	2	4.76	0	0.00
Age																						
18 years and under	6	0.8	101	13.5	10	1.3	1	0.1	1	0.1	0	0.0	50	6.7	36	4.8	10	1.3	21	2.8	15	2.0
19 – 35 years old	133	0.8	1869	11.2	154	0.9	5	0.0	15	0.1	23	0.1	972	5.8	86	0.5	269	1.6	956	5.7	259	1.6
36 – 50 years old	89	0.9	766	7.6	69	0.7	4	0.0	10	0.1	50	0.5	680	6.7	53	0.5	149	1.5	690	6.8	125	1.2
51 years and older	123	3.8	58	1.8	29	0.9	0	0.0	5	0.2	15	0.5	174	5.3	2	0.1	136	4.2	209	6.4	87	2.7
Ethnicity																						
White	325	1.2	2599	9.5	228	0.8	10	0.0	28	0.1	85	0.3	1576	5.7	147	0.5	483	1.8	1151	4.2	419	1.5
Asian / Asian British	15	0.8	99	5.1	15	0.8	0	0.0	1	0.1	1	0.1	183	9.4	12	0.6	37	1.9	503	25.9	32	1.6
Black / African / Caribbean / Black British	5	0.9	38	6.5	8	1.4	0	0.0	1	0.2	0	0.0	65	11.2	3	0.5	16	2.7	113	19.4	10	1.7
Mixed / Multiple ethnic groups	2	0.4	32	6.0	7	1.3	0	0.0	1	0.2	1	0.2	37	7.0	7	1.3	12	2.3	79	14.9	15	2.8
Other ethnic group	4	1.5	26	9.6	4	1.5	0	0.0	0	0.0	1	0.4	15	5.5	8	3.0	16	5.9	30	11.1	10	3.7
Sexuality																						
Heterosexuality	335	1.1	2738	9.1	249	0.8	10	0.0	31	0.1	85	0.3	1819	6.1	162	0.5	546	1.8	1829	6.1	469	1.6
Bisexual	4	0.9	47	10.2	7	1.5	0	0.0	0	0.0	2	0.4	33	7.1	8	1.7	9	1.9	21	4.5	11	2.4
Gay	4	2.9	2	1.4	3	2.2	0	0.0	0	0.0	0	0.0	5	3.6	1	0.7	4	2.9	9	6.5	3	2.2
Lesbian	7	3.3	5	2.4	1	0.5	0	0.0	0	0.0	1	0.5	16	7.7	3	1.4	3	1.4	16	7.7	1	0.5
Other	1	2.5	2	5.0	2	5.0	0	0.0	0	0.0	0	0.0	3	7.5	3	7.5	2	5.0	1	2.5	2	5.0
Disability																						
Disability	146	3.1	253	5.4	37	0.8	2	0.0	6	0.1	24	0.5	374	8.0	25	0.5	123	2.6	479	10.2	99	2.1
No disability	205	0.8	2541	9.7	225	0.9	8	0.0	25	0.1	64	0.2	1502	5.7	152	0.6	441	1.7	1397	5.3	387	1.5

Table A8: Referral Pathways by Independent Variable — This table presents the number and percentage of clients within each category of the independent variables who were referred through various referral routes. Percentages are calculated based on the total number of clients in each category (e.g., gender, age group, ethnicity, etc.).

Independent variable	Housing		Marac		MASH		Mental health		Other		Outreach		Police		Probation		Refuge		Self-referral		Specialist services	
Gender	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Male	24	*1.61*	68	*4.55*	107	*7.16*	46	*3.08*	47	*3.15*	28	*1.87*	440	*29.45*	7	*0.47*	4	*0.27*	377	*25.23*	17	*1.14*
Female	476	*1.63*	2151	*7.35*	2012	*6.87*	515	*1.76*	700	*2.39*	615	*2.10*	8060	*27.53*	103	*0.35*	333	*1.14*	5940	*20.29*	198	*0.68*
In another way	1	*2.38*	2	*4.76*	2	*4.76*	1	*2.38*	2	*4.76*	0	*0.00*	10	*23.81*	2	*4.76*	2	*4.76*	9	*21.43*	0	*0.00*
Age																						
18 years and under	10	*1.3*	41	*5.5*	67	*9.0*	13	*1.7*	17	*2.3*	10	*1.3*	235	*31.5*	0	*0.0*	5	*0.7*	90	*12.0*	8	*1.1*
19 – 35 years old	270	*1.6*	1321	*7.9*	1221	*7.3*	243	*1.5*	362	*2.2*	333	*2.0*	4691	*28.1*	66	*0.4*	217	*1.3*	3110	*18.6*	107	*0.6*
36 – 50 years old	167	*1.6*	645	*6.4*	647	*6.4*	184	*1.8*	273	*2.7*	223	*2.2*	2681	*26.5*	40	*0.4*	97	*1.0*	2404	*23.8*	76	*0.8*
51 years and older	54	*1.7*	214	*6.6*	186	*5.7*	122	*3.7*	97	*3.0*	77	*2.4*	903	*27.7*	6	*0.2*	20	*0.6*	722	*22.1*	24	*0.7*
Ethnicity																						
White	435	*1.6*	1948	*7.1*	2010	*7.3*	513	*1.9*	637	*2.3*	566	*2.1*	7969	*29.0*	107	*0.4*	235	*0.9*	5826	*21.2*	190	*0.7*
Asian / Asian British	28	*1.4*	163	*8.4*	68	*3.5*	21	*1.1*	68	*3.5*	46	*2.4*	284	*14.6*	2	*0.1*	67	*3.4*	287	*14.8*	12	*0.6*
Black / African / Caribbean / Black British	22	*3.8*	39	*6.7*	21	*3.6*	15	*2.6*	17	*2.9*	16	*2.7*	80	*13.7*	0	*0.0*	18	*3.1*	89	*15.3*	6	*1.0*
Mixed / Multiple ethnic groups	8	*1.5*	56	*10.6*	18	*3.4*	7	*1.3*	18	*3.4*	12	*2.3*	121	*22.8*	2	*0.4*	12	*2.3*	81	*15.3*	2	*0.4*
Other ethnic group	8	*3.0*	15	*5.5*	4	*1.5*	6	*2.2*	9	*3.3*	3	*1.1*	56	*20.7*	1	*0.4*	7	*2.6*	43	*15.9*	5	*1.8*
Sexuality																						
Heterosexuality	475	1.6	2170	7.2	2071	6.9	531	1.8	724	2.4	629	2.1	8298	27.7	109	0.4	326	1.1	6153	20.5	205	0.7
Bisexual	9	1.9	29	6.3	32	6.9	19	4.1	15	3.2	12	2.6	107	23.1	1	0.2	7	1.5	85	18.4	5	1.1
Gay	6	4.3	6	4.3	8	5.8	6	4.3	2	1.4	0	0.0	50	36.2	1	0.7	2	1.4	25	18.1	1	0.7
Lesbian	9	4.3	16	7.7	9	4.3	5	2.4	7	3.3	2	1.0	49	23.4	0	0.0	3	1.4	54	25.8	2	1.0
Other	2	5.0	0	0.0	1	2.5	1	2.5	1	2.5	0	0.0	6	15.0	1	2.5	1	2.5	9	22.5	2	5.0
Disability																						
Disability	97	*2.1*	451	*9.6*	353	*7.5*	159	*3.4*	124	*2.6*	102	*2.2*	927	*19.8*	15	*0.3*	57	*1.2*	789	*16.8*	42	*0.9*
No disability	404	*1.5*	1770	*6.8*	1768	*6.8*	403	*1.5*	625	*2.4*	541	*2.1*	7583	*29.0*	97	*0.4*	282	*1.1*	5537	*21.2*	173	*0.7*

Table A8 (continued): Referral Pathways by Independent Variable – This table presents the number and percentage of clients within each category of the independent variables who were referred through various referral routes. Percentages are calculated based on the total number of clients in each category (e.g., gender, age group, ethnicity, etc.).

Appendix 4: Cross-tabulations for the pairs of variables included in interaction effects

The table below presents cross-tabulations for the four pairs of variables included as interaction effects in the multilevel models: ethnicity and sexuality, age and sexuality, ethnicity and age, and ethnicity and disability.

Table A9: Crosstab of ethnicity and sexuality

Ethnicity X Sexuality	Heterosexual	Bisexual	Gay	Lesbian
White	25505	377	19	193
Asian / Asian British	1817	23	0	6
Black / African / Caribbean / Black British	526	18	0	2
Mixed / Multiple ethnic groups	493	13	0	2
Other ethnic group	249	3	0	3

Table A10: Crosstab of age and sexuality

Age X Sexuality	Heterosexual	Bisexual	Gay	Lesbian
18 and under	669	28	0	7
19-35	15691	275	10	113
35-50	9365	117	6	71
51 and older	2865	14	3	15

Table A11: Crosstab of ethnicity and age

Ethnicity X Age	18 and under	19-35	35-50	51 and older
White	628	14486	8307	2687
Asian / Asian British	42	900	766	142
Black / African / Caribbean / Black British	6	267	241	35
Mixed / Multiple ethnic groups	23	321	151	17
Other ethnic group	6	130	106	17

Table A12: Crosstab of ethnicity and disability

Ethnicity X Disability	Disability	No Disability
White	3869	22239
Asian / Asian British	262	1588

Black / African / Caribbean / Black British	80	469
Mixed / Multiple ethnic groups	83	429
Other ethnic group	39	220

Appendix 5: Output from the multi-level models outlined in the quantitative results section

Length of abuse

Table A13: output from the multi-level model examining the relationships between victim/survivors identities and the length of abuse experienced (in months) outlined in 4.1.2.1. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	71.62534	2.929229	24.45194	29.33369	4.64E-21
Gender: Male	-7.79964	2.081736	-3.7467	30733.51	0.00018
Age: 18 and under	-47.1034	2.86967	-16.4142	30729.89	2.73E-60
Age: 19-35	-32.7668	0.954874	-34.3153	30734.73	2.8E-253
Age: 51+	43.79081	1.538403	28.46512	30734.39	6.1E-176
Ethnicity: Asian / Asian British	20.65399	1.900541	10.86743	26022.12	1.89E-27
Ethnicity: Black / African / Caribbean / Black British	9.667144	3.225614	2.996994	30119.53	0.002729
Ethnicity: Mixed / Multiple ethnic groups	2.743236	3.343282	0.820522	30739.47	0.411925
Ethnicity: Other ethnic group	7.306828	4.714239	1.549948	29430.52	0.121165
Disability: Yes	4.307462	1.238479	3.478027	30685.1	0.000506
Sexual orientation: Bisexual	-8.99775	3.561363	-2.52649	30716.34	0.011526
Sexual orientation: Gay	-13.8462	6.72042	-2.06032	30714.62	0.039377
Sexual orientation: Lesbian	-15.3721	5.245231	-2.93068	30734.56	0.003385
Year opened centred	-1.75844	0.258923	-6.79136	19446.01	1.14E-11

Table A14: output from the multi-level model examining the relationships between victim/survivors identities and the length of abuse experienced (in months) outlined in 4.1.2.1.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation in abuse duration attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	71.90045	5.45196	13.188	46.50544	2.52E-17
Gender: Male	-5.78268	4.502199	-1.28441	49.90277	0.204928
Age: 18 and under	-38.2852	6.467473	-5.91965	64.51739	1.36E-07
Age: 19-35	-31.2909	4.162221	-7.51783	37.06914	5.79E-09
Age: 51+	34.75904	5.108772	6.803796	42.48698	2.62E-08
Ethnicity: Asian / Asian British	26.89206	5.005628	5.372365	40.93949	3.38E-06

Ethnicity: Black / African / Caribbean / Black British	5.495659	6.230976	0.88199	52.91724	0.381771
Ethnicity: Mixed / Multiple ethnic groups	2.294823	6.389431	0.359159	57.42325	0.720793
Ethnicity: Other ethnic group	7.623166	7.516429	1.014201	70.16831	0.313972
Disability: Yes	3.57807	3.688419	0.970082	46.93199	0.336979
Sexual orientation: Bisexual	-8.80146	5.746322	-1.53167	81.04342	0.129499
Sexual orientation: Gay	-18.2788	8.446202	-2.16415	167.4661	0.03187
Sexual orientation: Lesbian	-17.2837	7.656928	-2.25726	83.067	0.026616
Year opened centred	-1.75394	0.25856	-6.78348	19595.35	1.21E-11

Risk profile at intake

Table A15: output from the multi-level model examining the relationships between victim/survivors' identities and the risk identified at intake using the DASH RIC outlined in 4.1.2.2.1. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	10.70213	0.417398	25.64012	27.75053	7.3E-21
Gender: Male	-0.81044	0.121249	-6.68411	27645.65	2.37E-11
Age: 18 and under	0.003436	0.165651	0.020743	27641.75	0.983451
Age: 19-35	0.442205	0.055071	8.02968	27642.95	1.02E-15
Age: 51+	-0.83702	0.089176	-9.38617	27643.46	6.68E-21
Ethnicity: Asian / Asian British	-1.04225	0.10832	-9.62189	27608.98	7E-22
Ethnicity: Black / African / Caribbean / Black British	-1.10471	0.182423	-6.05579	27665.55	1.42E-09
Ethnicity: Mixed / Multiple ethnic groups	-0.00997	0.190059	-0.05245	27648.95	0.958169
Ethnicity: Other ethnic group	-0.46087	0.267187	-1.72491	27663.76	0.084556
Disability: Yes	0.469442	0.071681	6.549005	27657.9	5.89E-11
Sexual orientation: Bisexual	0.683827	0.204618	3.341973	27653.17	0.000833
Sexual orientation: Gay	0.518288	0.39365	1.316622	27639.16	0.187976
Sexual orientation: Lesbian	0.291618	0.306953	0.950041	27663.85	0.3421
Year opened centred	-0.11819	0.014922	-7.9207	27443.27	2.45E-15

Table A16: output from the multi-level model examining the relationships between victim/survivors identities and the risk identified at intake using the DASH RIC outlined in 4.1.2.2.1.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	10.75347	0.421092	25.53708	31.15274	1.87E-22
Gender: Male	-0.77519	0.143404	-5.40568	36.60092	4.13E-06
Age: 18 and under	-0.08154	0.20879	-0.39052	25.59424	0.699383
Age: 19-35	0.325669	0.11126	2.927095	10.43993	0.014482
Age: 51+	-0.86384	0.138981	-6.21555	11.6557	5.1E-05
Ethnicity: Asian / Asian British	-0.9828	0.143991	-6.82545	18.63469	1.81E-06

Ethnicity: Black / African / Caribbean / Black British	-1.10396	0.2078	-5.3126	56.50376	1.9E-06
Ethnicity: Mixed / Multiple ethnic groups	0.042661	0.216659	0.196906	57.7332	0.844593
Ethnicity: Other ethnic group	-0.43884	0.286057	-1.5341	172.4966	0.126837
Disability: Yes	0.433911	0.107833	4.023899	13.6452	0.001318
Sexual orientation: Bisexual	0.706459	0.221445	3.190231	138.6811	0.001758
Sexual orientation: Gay	0.53414	0.402566	1.326839	1257.079	0.184803
Sexual orientation: Lesbian	0.324163	0.320996	1.009866	365.8505	0.313227
Year opened centred	-0.11826	0.014915	-7.92859	27441.34	2.3E-15

Change in risk profile from intake to exit

Table A17: output from the multi-level model examining the relationships between victim/survivors' identities and changes in risk level over time, as measured by the DASH RIC outlined in 4.1.2.2.2. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.808833	0.452471	6.20776	23.51432	2.24E-06
Gender: Male	-0.34136	0.139057	-2.45485	15112.35	0.014106
Age: 18 and under	-0.14811	0.186144	-0.79568	15111.51	0.426233
Age: 19-35	0.126696	0.062704	2.020531	15113.15	0.043346
Age: 51+	0.049969	0.099869	0.500346	15112.17	0.616839
Ethnicity: Asian / Asian British	0.018423	0.11254	0.163704	15137.12	0.869967
Ethnicity: Black / African / Caribbean / Black British	0.190613	0.195597	0.974516	15132.21	0.329816
Ethnicity: Mixed / Multiple ethnic groups	-0.1571	0.203191	-0.77316	15117.97	0.439441
Ethnicity: Other ethnic group	0.694909	0.289678	2.398904	15130.28	0.016456
Disability: Yes	-0.17569	0.079886	-2.19922	15119.65	0.027877
Sexual orientation: Bisexual	0.195066	0.235724	0.827517	15132.94	0.407957
Sexual orientation: Gay	-0.24898	0.464554	-0.53596	15109.68	0.591992
Sexual orientation: Lesbian	0.32538	0.364562	0.892523	15112.39	0.372127
Year opened centred	-0.08731	0.018083	-4.82823	15056.16	1.39E-06

Table A18: output from the multi-level model examining the relationships between victim/survivors identities and changes in risk level over time outlined in 4.1.2.2.2.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.80935	0.442916	6.342843	24.31931	1.39E-06
Gender: Male	-0.34144	0.138997	-2.45643	15125.22	0.014044
Age: 18 and under	-0.14804	0.186064	-0.79566	15124.34	0.426244
Age: 19-35	0.126717	0.062677	2.021737	15126.04	0.043221
Age: 51+	0.049981	0.099826	0.500678	15125.03	0.616605
Ethnicity: Asian / Asian British	0.019013	0.112487	0.169019	15151.03	0.865784

Ethnicity: Black / African / Caribbean / Black British	0.191323	0.19551	0.978584	15145.96	0.327801
Ethnicity: Mixed / Multiple ethnic groups	-0.1569	0.203104	-0.77252	15131.09	0.439816
Ethnicity: Other ethnic group	0.696222	0.28955	2.404501	15143.97	0.016206
Disability: Yes	-0.17568	0.079851	-2.20013	15132.84	0.027813
Sexual orientation: Bisexual	0.196145	0.235619	0.832465	15146.71	0.40516
Sexual orientation: Gay	-0.24893	0.464356	-0.53608	15122.43	0.591914
Sexual orientation: Lesbian	0.325915	0.364407	0.894372	15125.27	0.371137
Year opened centred	-0.08732	0.018074	-4.8315	15065.39	1.37E-06

Safety

Table A19: output from the multi-level model examining the relationships between victim/survivors' identities and their self-reported perceptions of safety at case closure outlined in 4.1.2.3.1. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.23304	0.040235	105.2075	23.66989	4E-33
Gender: Male	-0.08125	0.029179	-2.78458	14484.19	0.005367
Age: 18 and under	0.046155	0.039757	1.160913	14475.13	0.245696
Age: 19-35	0.036621	0.013311	2.751105	14483.99	0.005947
Age: 51+	0.004164	0.021197	0.19644	14482.9	0.844268
Ethnicity: Asian / Asian British	0.128756	0.024687	5.215539	13596.2	1.86E-07
Ethnicity: Black / African / Caribbean / Black British	0.106652	0.042751	2.494739	14402.76	0.012616
Ethnicity: Mixed / Multiple ethnic groups	0.051489	0.044184	1.165335	14492.08	0.243903
Ethnicity: Other ethnic group	0.172179	0.062285	2.764384	14460.48	0.00571
Disability: Yes	-0.0295	0.017318	-1.70335	14493.95	0.088523
Sexual orientation: Bisexual	0.124364	0.051602	2.410033	14456.22	0.015963
Sexual orientation: Gay	-0.01113	0.091855	-0.12113	14468.6	0.903593
Sexual orientation: Lesbian	0.102937	0.080686	1.275765	14488.48	0.202059
Year opened centred	-0.0081	0.003922	-2.0647	10370.97	0.038977

Table A20: output from the multi-level model examining the relationships between victim/survivors identities and their self-reported perceptions of safety at case closure outlined in 4.1.2.3.1.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.232793	0.039309	107.6811	24.59844	2.05E-34
Gender: Male	-0.08124	0.029166	-2.78531	14497.73	0.005355
Age: 18 and under	0.046171	0.039739	1.161842	14488.16	0.245319
Age: 19-35	0.036639	0.013305	2.753742	14497.46	0.005899
Age: 51+	0.004185	0.021187	0.197516	14496.33	0.843426
Ethnicity: Asian / Asian British	0.129008	0.024669	5.229559	13571.67	1.72E-07

Ethnicity: Black / African / Caribbean / Black British	0.106729	0.042727	2.497932	14416.33	0.012503
Ethnicity: Mixed / Multiple ethnic groups	0.051437	0.044163	1.16469	14505.82	0.244164
Ethnicity: Other ethnic group	0.17264	0.062252	2.773257	14473.89	0.005557
Disability: Yes	-0.02953	0.017309	-1.70618	14508.01	0.087996
Sexual orientation: Bisexual	0.124571	0.051575	2.415341	14471.64	0.015733
Sexual orientation: Gay	-0.01113	0.091814	-0.12121	14481.31	0.90353
Sexual orientation: Lesbian	0.102941	0.080649	1.276412	14501.99	0.20183
Year opened centred	-0.00809	0.003918	-2.06593	10207.38	0.03886

Wellbeing

Table A21: output from the multi-level model examining the relationships between victim/survivors' identities and their self-reported perceptions of wellbeing at case closure outlined in 4.1.2.3.2. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.128951	0.042738	96.6115	24.27189	6.62E-33
Gender: Male	-0.14841	0.030819	-4.81559	14385.7	1.48E-06
Age: 18 and under	0.040871	0.042127	0.970191	14375.94	0.331968
Age: 19-35	0.026931	0.014069	1.914194	14385.28	0.055615
Age: 51+	-0.00657	0.022405	-0.2931	14383.7	0.769453
Ethnicity: Asian / Asian British	0.092911	0.0261	3.559844	13543.73	0.000372
Ethnicity: Black / African / Caribbean / Black British	0.131148	0.04543	2.886812	14298.47	0.003897
Ethnicity: Mixed / Multiple ethnic groups	0.00236	0.046556	0.050698	14391.15	0.959567
Ethnicity: Other ethnic group	0.141205	0.065877	2.143475	14363.22	0.032092
Disability: Yes	-0.0767	0.018314	-4.18807	14394.33	2.83E-05
Sexual orientation: Bisexual	0.146367	0.054381	2.691521	14359.14	0.007121
Sexual orientation: Gay	0.116608	0.097496	1.196032	14370.71	0.231704
Sexual orientation: Lesbian	0.113142	0.086065	1.314603	14387.4	0.188664
Year opened centred	-0.01357	0.004143	-3.27512	10474.04	0.00106

Table A22: output from the multi-level model examining the relationships between victim/survivors identities and their self-reported perceptions of wellbeing at case closure outlined in 4.1.2.3.2.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.128885	0.041777	98.83115	25.16408	4.06E-34
Gender: Male	-0.14841	0.030805	-4.81771	14399.23	1.47E-06
Age: 18 and under	0.040892	0.042108	0.971121	14388.93	0.331504
Age: 19-35	0.02695	0.014062	1.916481	14398.72	0.055324
Age: 51+	-0.00656	0.022395	-0.29285	14397.08	0.769643
Ethnicity: Asian / Asian British	0.09325	0.026081	3.575428	13521.12	0.000351

Ethnicity: Black / African / Caribbean / Black British	0.131293	0.045405	2.891619	14312.05	0.003838
Ethnicity: Mixed / Multiple ethnic groups	0.002373	0.046534	0.050998	14404.81	0.959328
Ethnicity: Other ethnic group	0.141763	0.065842	2.153091	14376.66	0.031328
Disability: Yes	-0.07674	0.018305	-4.19244	14408.43	2.78E-05
Sexual orientation: Bisexual	0.146576	0.054352	2.696793	14374.43	0.007009
Sexual orientation: Gay	0.116583	0.097452	1.196312	14383.41	0.231595
Sexual orientation: Lesbian	0.113242	0.086025	1.316379	14400.75	0.188068
Year opened centred	-0.01355	0.004139	-3.27329	10316.87	0.001067

Quality of life

Table A23: output from the multi-level model examining the relationships between victim/survivors' identities and their self-reported perceptions of quality of life at case closure outlined in 4.1.2.3.3. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.052713	0.044622	90.82244	25.25997	2.69E-33
Gender: Male	-0.14487	0.031829	-4.5515	14325.58	5.37E-06
Age: 18 and under	0.056481	0.043419	1.300811	14316.55	0.193344
Age: 19-35	0.042154	0.014529	2.901396	14325.23	0.003721
Age: 51+	-0.02751	0.023131	-1.18937	14323.93	0.234312
Ethnicity: Asian / Asian British	0.079461	0.026904	2.95351	13564.94	0.003147
Ethnicity: Black / African / Caribbean / Black British	0.104272	0.046899	2.223335	14247.69	0.026209
Ethnicity: Mixed / Multiple ethnic groups	0.026007	0.047981	0.542023	14330.98	0.587811
Ethnicity: Other ethnic group	0.086501	0.067896	1.274019	14306.9	0.202678
Disability: Yes	-0.06778	0.01893	-3.58047	14334.69	0.000344
Sexual orientation: Bisexual	0.163325	0.056324	2.899759	14301.48	0.00374
Sexual orientation: Gay	0.065863	0.10049	0.655412	14311.71	0.512213
Sexual orientation: Lesbian	0.132492	0.088176	1.50259	14329.82	0.132967
Year opened centred	-0.01256	0.004278	-2.93514	10702.77	0.003341

Table A24: output from the multi-level model examining the relationships between victim/survivors identities and their self-reported perceptions of quality of life at case closure outlined in 4.1.2.3.3.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	4.052486	0.04366	92.81831	26.22252	1.5E-34
Gender: Male	-0.14487	0.031814	-4.55372	14339.08	5.31E-06
Age: 18 and under	0.056503	0.0434	1.301916	14329.59	0.192966
Age: 19-35	0.042181	0.014522	2.904635	14338.66	0.003682
Age: 51+	-0.0275	0.02312	-1.18948	14337.31	0.23427
Ethnicity: Asian / Asian British	0.079797	0.026885	2.96808	13549.35	0.003002

Ethnicity: Black / African / Caribbean / Black British	0.104378	0.046873	2.226834	14261.69	0.025974
Ethnicity: Mixed / Multiple ethnic groups	0.026016	0.047958	0.542463	14344.62	0.587508
Ethnicity: Other ethnic group	0.087001	0.06786	1.282051	14320.58	0.199846
Disability: Yes	-0.06781	0.01892	-3.58401	14348.81	0.000339
Sexual orientation: Bisexual	0.163445	0.056294	2.903435	14316.78	0.003697
Sexual orientation: Gay	0.065827	0.100445	0.655349	14324.5	0.512253
Sexual orientation: Lesbian	0.132594	0.088135	1.504445	14343.33	0.132489
Year opened centred	-0.01251	0.004274	-2.9282	10569.27	0.003417

Physical abuse – intake

Table A25: output from the multi-level model examining the relationships between victim/survivors' identities and the level of physical abuse reported at intake outlined in 4.1.2.4.1. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.373711	0.091826	25.85006	28.37317	2.88E-21
Gender: Male	-0.01835	0.033815	-0.54262	29976.64	0.587398
Age: 18 and under	0.277855	0.046834	5.932756	29973.04	3.01E-09
Age: 19-35	0.194571	0.01547	12.57706	29976.26	3.49E-36
Age: 51+	-0.06259	0.024921	-2.51177	29976.01	0.012018
Ethnicity: Asian / Asian British	-0.11161	0.030966	-3.60427	29702.01	0.000314
Ethnicity: Black / African / Caribbean / Black British	-0.10605	0.052701	-2.01221	29979.44	0.044206
Ethnicity: Mixed / Multiple ethnic groups	0.000413	0.054201	0.007616	29984.8	0.993924
Ethnicity: Other ethnic group	0.10631	0.076559	1.388593	29951.92	0.164967
Disability: Yes	0.019758	0.020129	0.981549	29994.34	0.32633
Sexual orientation: Bisexual	-0.01821	0.057617	-0.31598	29989.84	0.752022
Sexual orientation: Gay	0.304966	0.110049	2.77117	29968.73	0.005589
Sexual orientation: Lesbian	0.127686	0.085429	1.494634	29991.32	0.135021
Year opened centred	-0.04563	0.004234	-10.7785	29118.47	4.89E-27

Table A26: output from the multi-level model examining the relationships between victim/survivors identities and the level of physical abuse reported at intake outlined in 4.1.2.4.1.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.373824	0.090195	26.31888	29.39737	5.46E-22
Gender: Male	-0.01835	0.033808	-0.5429	29989.78	0.587199
Age: 18 and under	0.277882	0.046824	5.934635	29986.21	2.98E-09
Age: 19-35	0.194582	0.015467	12.58053	29989.51	3.34E-36
Age: 51+	-0.0626	0.024915	-2.51261	29989.24	0.011989
Ethnicity: Asian / Asian British	-0.11149	0.030957	-3.60155	29706.05	0.000317

Ethnicity: Black / African / Caribbean / Black British	-0.106	0.052688	-2.01178	29993.13	0.044252
Ethnicity: Mixed / Multiple ethnic groups	0.000445	0.054189	0.008218	29998.36	0.993443
Ethnicity: Other ethnic group	0.106522	0.07654	1.391721	29964.36	0.164017
Disability: Yes	0.019777	0.020124	0.982732	30008.25	0.325747
Sexual orientation: Bisexual	-0.01814	0.057604	-0.31491	30003.62	0.752831
Sexual orientation: Gay	0.30495	0.110026	2.771627	29981.71	0.005581
Sexual orientation: Lesbian	0.127717	0.08541	1.495346	30004.58	0.134835
Year opened centred	-0.04561	0.004232	-10.7772	29100.28	4.96E-27

Physical abuse – change

Table A27: output from the multi-level model examining the relationships between victim/survivors' identities and the change in their experiences of physical abuse between case opening and case closure outlined in 4.1.2.4.2. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.077928	0.090977	11.84831	25.67503	6.59E-12
Gender: Male	0.012481	0.045417	0.274813	19260.08	0.783463
Age: 18 and under	0.242936	0.063187	3.84473	19256.61	0.000121
Age: 19-35	0.161973	0.020772	7.797711	19260.77	6.62E-15
Age: 51+	-0.04089	0.032943	-1.24128	19259.7	0.214517
Ethnicity: Asian / Asian British	-0.04127	0.039501	-1.0449	18956.58	0.296082
Ethnicity: Black / African / Caribbean / Black British	-0.07363	0.069616	-1.05764	19259.47	0.290234
Ethnicity: Mixed / Multiple ethnic groups	0.034916	0.070844	0.492851	19269.91	0.622123
Ethnicity: Other ethnic group	0.25885	0.099155	2.610563	19271.09	0.009046
Disability: Yes	-0.04352	0.026745	-1.62737	19275.68	0.103675
Sexual orientation: Bisexual	-0.07501	0.077706	-0.96526	19271.72	0.334427
Sexual orientation: Gay	0.163815	0.149436	1.096224	19251.28	0.272994
Sexual orientation: Lesbian	0.030997	0.124055	0.249864	19260.2	0.802695
Year opened centred	-0.03384	0.006008	-5.63196	17649.21	1.81E-08

Table A28: output from the multi-level model examining the relationships between victim/survivors identities and the change in their experiences of physical abuse between case opening and case closure outlined in 4.1.2.4.2.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.07809	0.089152	12.09267	26.66024	2.49E-12
Gender: Male	0.012442	0.045402	0.274036	19273.37	0.78406
Age: 18 and under	0.243004	0.063165	3.847098	19269.75	0.00012
Age: 19-35	0.162012	0.020765	7.802207	19274.01	6.39E-15
Age: 51+	-0.04088	0.032932	-1.24145	19272.97	0.214453

Ethnicity: Asian / Asian British	-0.04103	0.039483	-1.0391	18959.59	0.298773
Ethnicity: Black / African / Caribbean / Black British	-0.07346	0.069589	-1.05569	19273.53	0.291122
Ethnicity: Mixed / Multiple ethnic groups	0.034959	0.07082	0.493635	19283.53	0.62157
Ethnicity: Other ethnic group	0.259171	0.099117	2.614787	19285.09	0.008935
Disability: Yes	-0.04352	0.026735	-1.6279	19289.52	0.103562
Sexual orientation: Bisexual	-0.07481	0.077677	-0.96307	19285.99	0.335525
Sexual orientation: Gay	0.163812	0.149385	1.096572	19264.17	0.272842
Sexual orientation: Lesbian	0.031055	0.124013	0.250419	19273.44	0.802266
Year opened centred	-0.0338	0.006004	-5.62877	17595.53	1.84E-08

Sexual abuse – intake

Table A29: output from the multi-level model examining the relationships between victim/survivors' identities and the level of sexual abuse reported at intake outlined in 4.1.2.4.3. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.537016	0.055145	27.87219	27.59237	9.49E-22
Gender: Male	-0.25519	0.027001	-9.45103	29055.59	3.6E-21
Age: 18 and under	0.226856	0.037643	6.026568	29051.53	1.69E-09
Age: 19-35	0.028409	0.012434	2.284698	29057.13	0.022338
Age: 51+	-0.18374	0.019932	-9.21842	29056.53	3.21E-20
Ethnicity: Asian / Asian British	0.089478	0.024855	3.600031	27935.28	0.000319
Ethnicity: Black / African / Caribbean / Black British	0.129315	0.042171	3.066444	28921.89	0.002168
Ethnicity: Mixed / Multiple ethnic groups	-0.02797	0.043636	-0.6409	29067.63	0.52159
Ethnicity: Other ethnic group	0.193002	0.061895	3.118214	28811.16	0.001821
Disability: Yes	0.136723	0.01616	8.460635	29069.1	2.78E-17
Sexual orientation: Bisexual	0.142806	0.046399	3.077823	29070.99	0.002087
Sexual orientation: Gay	0.324257	0.089494	3.62324	29044.7	0.000291
Sexual orientation: Lesbian	0.02763	0.068602	0.402751	29065.36	0.687134
Year opened centred	0.003848	0.003387	1.13608	26090.04	0.255933

Table A30: output from the multi-level model examining the relationships between victim/survivors identities and the level of sexual abuse reported at intake outlined in 4.1.2.4.3.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.55253	0.062236	24.94583	36.64376	1.37E-24
Gender: Male	-0.27176	0.03697	-7.35096	31.76172	2.44E-08
Age: 18 and under	0.174001	0.055503	3.13498	30.48926	0.003786
Age: 19-35	0.076292	0.03146	2.42501	18.06966	0.026008
Age: 51+	-0.17717	0.038926	-4.55144	17.60216	0.000261
Ethnicity: Asian / Asian British	0.030483	0.039245	0.776748	23.25309	0.445138

Ethnicity: Black / African / Caribbean / Black British	0.090471	0.053526	1.690237	46.59371	0.097663
Ethnicity: Mixed / Multiple ethnic groups	-0.06144	0.05552	-1.10655	47.61845	0.274049
Ethnicity: Other ethnic group	0.161918	0.070783	2.287532	110.0629	0.024076
Disability: Yes	0.094107	0.029649	3.173997	22.37005	0.004332
Sexual orientation: Bisexual	0.117074	0.054265	2.15746	92.38595	0.033564
Sexual orientation: Gay	0.316843	0.094157	3.36503	581.2349	0.000816
Sexual orientation: Lesbian	-0.00296	0.075655	-0.03915	185.26	0.968814
Year opened centred	0.003611	0.003385	1.066778	26117.92	0.286082

Sexual abuse – change

Table A31: output from the multi-level model examining the relationships between victim/survivors' identities and the change in their experiences of sexual abuse between case opening and case closure outlined in 4.1.2.4.4. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.537016	0.055145	27.87219	27.59237	9.49E-22
Gender: Male	-0.25519	0.027001	-9.45103	29055.59	3.6E-21
Age: 18 and under	0.226856	0.037643	6.026568	29051.53	1.69E-09
Age: 19-35	0.028409	0.012434	2.284698	29057.13	0.022338
Age: 51+	-0.18374	0.019932	-9.21842	29056.53	3.21E-20
Ethnicity: Asian / Asian British	0.089478	0.024855	3.600031	27935.28	0.000319
Ethnicity: Black / African / Caribbean / Black British	0.129315	0.042171	3.066444	28921.89	0.002168
Ethnicity: Mixed / Multiple ethnic groups	-0.02797	0.043636	-0.6409	29067.63	0.52159
Ethnicity: Other ethnic group	0.193002	0.061895	3.118214	28811.16	0.001821
Disability: Yes	0.136723	0.01616	8.460635	29069.1	2.78E-17
Sexual orientation: Bisexual	0.142806	0.046399	3.077823	29070.99	0.002087
Sexual orientation: Gay	0.324257	0.089494	3.62324	29044.7	0.000291
Sexual orientation: Lesbian	0.02763	0.068602	0.402751	29065.36	0.687134
Year opened centred	0.003848	0.003387	1.13608	26090.04	0.255933

Table A32: output from the multi-level model examining the relationships between victim/survivors identities and the change in their experiences of sexual abuse between case opening and case closure outlined in 4.1.2.4.4.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.07809	0.089152	12.09267	26.66024	2.49E-12
Gender: Male	0.012442	0.045402	0.274036	19273.37	0.78406
Age: 18 and under	0.243004	0.063165	3.847098	19269.75	0.00012
Age: 19-35	0.162012	0.020765	7.802207	19274.01	6.39E-15
Age: 51+	-0.04088	0.032932	-1.24145	19272.97	0.214453

Ethnicity: Asian / Asian British	-0.04103	0.039483	-1.0391	18959.59	0.298773
Ethnicity: Black / African / Caribbean / Black British	-0.07346	0.069589	-1.05569	19273.53	0.291122
Ethnicity: Mixed / Multiple ethnic groups	0.034959	0.07082	0.493635	19283.53	0.62157
Ethnicity: Other ethnic group	0.259171	0.099117	2.614787	19285.09	0.008935
Disability: Yes	-0.04352	0.026735	-1.6279	19289.52	0.103562
Sexual orientation: Bisexual	-0.07481	0.077677	-0.96307	19285.99	0.335525
Sexual orientation: Gay	0.163812	0.149385	1.096572	19264.17	0.272842
Sexual orientation: Lesbian	0.031055	0.124013	0.250419	19273.44	0.802266
Year opened centred	-0.0338	0.006004	-5.62877	17595.53	1.84E-08

Harassment and stalking – intake

Table A33: output from the multi-level model examining the relationships between victim/survivors' identities and the level of harassment and stalking reported at intake outlined in 4.1.2.4.5. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.316966	0.084026	27.57456	26.2338	6.65E-21
Gender: Male	-0.22577	0.033084	-6.82425	29542.84	9.01E-12
Age: 18 and under	0.054051	0.045623	1.184725	29538.85	0.236136
Age: 19-35	0.089564	0.015105	5.929588	29542.95	3.07E-09
Age: 51+	-0.26892	0.024266	-11.0824	29542.83	1.74E-28
Ethnicity: Asian / Asian British	-0.37319	0.030331	-12.3039	29118.64	1.05E-34
Ethnicity: Black / African / Caribbean / Black British	-0.39519	0.051388	-7.69034	29524.9	1.51E-14
Ethnicity: Mixed / Multiple ethnic groups	-0.12292	0.052839	-2.32629	29552.12	0.02001
Ethnicity: Other ethnic group	-0.23994	0.074618	-3.21563	29495.18	0.001303
Disability: Yes	-0.03163	0.019674	-1.60783	29561.91	0.107882
Sexual orientation: Bisexual	0.054567	0.056287	0.969451	29558.16	0.332328
Sexual orientation: Gay	0.098413	0.107985	0.911363	29533.81	0.362112
Sexual orientation: Lesbian	0.139842	0.083429	1.676171	29557.43	0.093715
Year opened centred	-0.02547	0.004129	-6.1694	28336.24	6.95E-10

Table A34: output from the multi-level model examining the relationships between victim/survivors identities and the level of harassment and stalking reported at intake outlined in 4.1.2.4.3.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.318032	0.089422	25.92236	34.7331	2.6E-24
Gender: Male	-0.202	0.044341	-4.55568	38.90069	5.05E-05
Age: 18 and under	0.043796	0.065961	0.663959	36.03735	0.510943
Age: 19-35	-0.00729	0.037366	-0.19517	20.7565	0.847155
Age: 51+	-0.2522	0.04621	-5.45764	20.30122	2.3E-05
Ethnicity: Asian / Asian British	-0.31222	0.046889	-6.65871	27.38373	3.54E-07

Ethnicity: Black / African / Caribbean / Black British	-0.35282	0.064348	-5.48306	56.83813	1E-06
Ethnicity: Mixed / Multiple ethnic groups	-0.06214	0.066276	-0.93764	58.09514	0.352313
Ethnicity: Other ethnic group	-0.18615	0.084726	-2.19705	135.4164	0.029718
Disability: Yes	-0.01418	0.035319	-0.40152	25.72889	0.691352
Sexual orientation: Bisexual	0.107314	0.065209	1.645699	114.4684	0.102569
Sexual orientation: Gay	0.142534	0.113292	1.258106	721.3443	0.208761
Sexual orientation: Lesbian	0.178858	0.091303	1.95896	239.904	0.051276
Year opened centred	-0.02529	0.004126	-6.12919	28286.78	8.95E-10

Harassment and stalking – change

Table A35: output from the multi-level model examining the relationships between victim/survivors' identities and the change in their experiences of harassment and stalking between case opening and case closure outlined in 4.1.2.4.6. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	0.806545	0.069795	11.55594	22.31518	6.84E-11
Gender: Male	-0.18883	0.043993	-4.29232	18675.32	1.78E-05
Age: 18 and under	0.080773	0.061056	1.322928	18668.95	0.185875
Age: 19-35	0.116467	0.020061	5.805541	18675.94	6.52E-09
Age: 51+	-0.15709	0.031722	-4.95204	18674.59	7.41E-07
Ethnicity: Asian / Asian British	-0.27034	0.038214	-7.07426	17739.54	1.56E-12
Ethnicity: Black / African / Caribbean / Black British	-0.26188	0.066779	-3.92163	18619.24	8.83E-05
Ethnicity: Mixed / Multiple ethnic groups	-0.0776	0.068546	-1.13207	18682.9	0.257618
Ethnicity: Other ethnic group	-0.23821	0.096201	-2.47612	18656.67	0.013291
Disability: Yes	-0.06434	0.025859	-2.48816	18688.88	0.012849
Sexual orientation: Bisexual	0.078827	0.074294	1.061014	18670.05	0.288697
Sexual orientation: Gay	0.038632	0.143292	0.269601	18659.88	0.78747
Sexual orientation: Lesbian	0.099143	0.119108	0.832378	18673.85	0.405206
Year opened centred	-0.00316	0.005775	-0.54679	14584.01	0.584534

Table A36: output from the multi-level model examining the relationships between victim/survivors identities and the change in their experiences of harassment and stalking between case opening and case closure outlined in 4.1.2.4.4.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	0.805611	0.072563	11.10219	23.01536	1.02E-10
Gender: Male	-0.17632	0.047863	-3.68396	44.87285	0.000615
Age: 18 and under	0.070993	0.069435	1.022432	24.20761	0.316686
Age: 19-35	0.071404	0.03387	2.108155	4.922191	0.089708
Age: 51+	-0.15024	0.042437	-3.54032	7.306232	0.008825
Ethnicity: Asian / Asian British	-0.24367	0.045499	-5.35552	14.33711	9.35E-05

Ethnicity: Black / African / Caribbean / Black British	-0.23909	0.071565	-3.34095	65.96665	0.001378
Ethnicity: Mixed / Multiple ethnic groups	-0.04453	0.073702	-0.60425	63.02057	0.547845
Ethnicity: Other ethnic group	-0.21281	0.09981	-2.13212	209.993	0.034159
Disability: Yes	-0.05023	0.033626	-1.4937	8.253612	0.172463
Sexual orientation: Bisexual	0.105626	0.077507	1.362785	167.8083	0.174776
Sexual orientation: Gay	0.051101	0.144746	0.35304	2111.951	0.724094
Sexual orientation: Lesbian	0.118767	0.12133	0.978876	757.2087	0.327954
Year opened centred	-0.00301	0.005769	-0.52125	14386.18	0.602198

Jealous and controlling behaviour – intake

Table A37: output from the multi-level model examining the relationships between victim/survivors' identities and the level of jealous and controlling behaviour reported at intake outlined in 4.1.2.4.7. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.708507	0.086247	31.40397	27.33902	5.46E-23
Gender: Male	-0.20801	0.030299	-6.86539	29640.84	6.76E-12
Age: 18 and under	0.163496	0.041637	3.926724	29636.45	8.63E-05
Age: 19-35	0.068061	0.013831	4.920736	29639.61	8.67E-07
Age: 51+	-0.14886	0.022252	-6.68987	29640.32	2.27E-11
Ethnicity: Asian / Asian British	-0.01732	0.027734	-0.62442	29417.03	0.532356
Ethnicity: Black / African / Caribbean / Black British	-0.05713	0.046863	-1.21911	29646.47	0.222812
Ethnicity: Mixed / Multiple ethnic groups	-0.07161	0.048307	-1.48241	29647.94	0.138243
Ethnicity: Other ethnic group	0.139154	0.068237	2.039277	29630.33	0.041431
Disability: Yes	-0.00966	0.018	-0.5367	29658.86	0.591478
Sexual orientation: Bisexual	0.110788	0.051826	2.13768	29652.81	0.032551
Sexual orientation: Gay	0.230189	0.098343	2.340679	29632.84	0.019255
Sexual orientation: Lesbian	0.171616	0.075981	2.258683	29656.26	0.02391
Year opened centred	-0.01196	0.003786	-3.15961	28952.46	0.001581

Table A38: output from the multi-level model examining the relationships between victim/survivors identities and the level of jealous and controlling behaviour reported at intake outlined in 4.1.2.4.3.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	2.708988	0.084662	31.99768	28.29833	9.1E-24
Gender: Male	-0.20802	0.030292	-6.86708	29653.92	6.68E-12
Age: 18 and under	0.16351	0.041628	3.927907	29649.54	8.59E-05
Age: 19-35	0.068061	0.013828	4.92182	29652.68	8.62E-07
Age: 51+	-0.14886	0.022247	-6.69133	29653.5	2.25E-11
Ethnicity: Asian / Asian British	-0.01726	0.027726	-0.62269	29421.88	0.533492

Ethnicity: Black / African / Caribbean / Black British	-0.05708	0.046851	-1.21836	29660.11	0.223096
Ethnicity: Mixed / Multiple ethnic groups	-0.0716	0.048296	-1.48256	29661.44	0.138201
Ethnicity: Other ethnic group	0.139312	0.068219	2.042108	29643.05	0.04115
Disability: Yes	-0.00966	0.017996	-0.53656	29672.74	0.591573
Sexual orientation: Bisexual	0.110861	0.051815	2.13956	29666.54	0.032398
Sexual orientation: Gay	0.230192	0.098321	2.341215	29645.76	0.019228
Sexual orientation: Lesbian	0.171618	0.075963	2.259223	29669.49	0.023877
Year opened centred	-0.01196	0.003785	-3.15863	28937.7	0.001587

Jealous and controlling behaviour – change

Table A39: output from the multi-level model examining the relationships between victim/survivors' identities and the change in their experiences of jealous and controlling behaviour between case opening and case closure outlined in 4.1.2.4.8. It included a random intercept for service provider to account for clustering at the service level.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.091999	0.08762	12.46292	22.81483	1.16E-11
Gender: Male	-0.23091	0.044474	-5.19201	18614.74	2.1E-07
Age: 18 and under	0.197119	0.061583	3.200844	18610.06	0.001373
Age: 19-35	0.132929	0.020314	6.543757	18614.29	6.16E-11
Age: 51+	-0.10038	0.032202	-3.11729	18614.77	0.001828
Ethnicity: Asian / Asian British	0.000326	0.038709	0.008434	18266.94	0.993271
Ethnicity: Black / African / Caribbean / Black British	0.000854	0.067874	0.012577	18611.52	0.989966
Ethnicity: Mixed / Multiple ethnic groups	-0.0339	0.068981	-0.49137	18622.67	0.623169
Ethnicity: Other ethnic group	0.142932	0.09775	1.462222	18623.45	0.143697
Disability: Yes	-0.06914	0.026158	-2.64337	18632.02	0.008215
Sexual orientation: Bisexual	0.04977	0.075635	0.65803	18624.55	0.510527
Sexual orientation: Gay	0.218648	0.145816	1.499481	18604.47	0.133766
Sexual orientation: Lesbian	0.152405	0.11943	1.276102	18615.04	0.201935
Year opened centred	0.001655	0.005871	0.281822	16878.12	0.778083

Table A40: output from the multi-level model examining the relationships between victim/survivors identities and the change in their experiences of jealous and controlling behaviour between case opening and case closure outlined in 4.1.2.4.4.2 It included a random intercept for service provider to account for clustering at the service level. Another random intercept was added that was identify strata this involved the unique combinations of the five demographic variables (age, gender, ethnicity, sexuality, disability) to account for group-level residual variation attributable to intersectional demographic profiles.

Variable	Estimate	Standard error	T-value	Degrees of freedom	P-value
(Intercept)	1.092176	0.08564	12.75304	23.61211	4.45E-12
Gender: Male	-0.23094	0.044458	-5.19458	18627.96	2.07E-07
Age: 18 and under	0.197199	0.061562	3.203263	18623.04	0.001361
Age: 19-35	0.132964	0.020307	6.547797	18627.43	5.99E-11
Age: 51+	-0.10038	0.032191	-3.11817	18627.95	0.001823

Ethnicity: Asian / Asian British	0.00058	0.03869	0.014982	18263.75	0.988047
Ethnicity: Black / African / Caribbean / Black British	0.000947	0.067847	0.013957	18625.2	0.988864
Ethnicity: Mixed / Multiple ethnic groups	-0.03389	0.068956	-0.49147	18636.19	0.623098
Ethnicity: Other ethnic group	0.143274	0.097712	1.4663	18637.18	0.142583
Disability: Yes	-0.06916	0.026148	-2.64508	18645.9	0.008174
Sexual orientation: Bisexual	0.050017	0.075605	0.661557	18638.77	0.508263
Sexual orientation: Gay	0.218661	0.145765	1.500092	18617.13	0.133608
Sexual orientation: Lesbian	0.152455	0.119389	1.276968	18628.18	0.201629
Year opened centred	0.001693	0.005868	0.288539	16794.13	0.772938