

DOMESTIC VIOLENCE DURING THE LOCKDOWN:

the needs of Black and minoritised communities during the pandemic

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Abstract

The UK's lockdown measures, announced on 23rd March 2020 in response to the COVID-19 pandemic, focused on encouraging people to stay at home to keep themselves and their communities safe. However, for those living with perpetrators of domestic violence and abuse, such isolation is potentially more dangerous than catching the virus. Shortly after the lockdown began, charities, police and other frontline support services began reporting a huge surge in victims/survivors' seeking help, placing additional strain on a sector already functioning beyond capacity. In addition to the increase in demand, the need to maintain social distancing has impacted hugely on the day-to-day working practices of these services. Based on interviews with 26 practitioners working in Black and minority ethnic (BME)² specialist services in England and Wales, this briefing paper explores the impact of the pandemic on

domestic violence in BME communities and on the services that support them.

Keywords:

austerity; COVID-19; Black and minority ethnic / BME communities; domestic violence and abuse; social distancing

Introduction

Since early 2020, the COVID-19 pandemic and global policy responses to it have led to changes in people's behavioural patterns, shutdowns of businesses, roll-backs of statutory services and the closure of educational institutions, particularly schools. The requirement for families to remain socially isolated in their homes has resulted not only in intense and unrelieved contact, but also separation from wider support networks, including family, friends and the community. While these

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2 The term Black and minority ethnic (BME) is commonly used in the UK policy context, and has come to be the dominant acronym to refer to communities that have been racialised as the 'other'. The term is problematic as it homogenises diverse communities, presumes that the default identity is White, and is not a term that people it refers to would identify themselves as; their self-identifications are more specific - e.g., African-Caribbean, Black British, British Asian etc. While aware of its limitations, we use the term BME here because of its recognition in common parlance.

strategies are necessary to stop the spread of the pandemic, home is not a place of safety for everyone. Isolating at home effectively traps victims/survivors of domestic violence and abuse (DVA) with their abusers. Social isolation also puts children at greater risk of physical, emotional and sexual abuse and neglect (NSPCC, 2020).

DVA is best defined as a pattern of coercive, controlling and/or abusive behaviours, physical, psychological, sexual and/or economic. It includes forced marriage and 'honour'-based violence. Although men do experience DVA, research on the amount, severity and impact of DVA consistently finds that its victims are predominantly women and girls and that the vast majority of perpetrators are men and boys (Walby and Towers, 2017).

During the pandemic, shortages of essential resources, and the devastating economic fallout, have meant that people across the world are living under uniquely stressful conditions. Evidence from around the globe demonstrates that COVID-19-induced lockdown, and associated physical-distancing measures, have resulted in a significant increase in violence against women and children (Campbell, 2020; UN Women, 2020). Several countries have reported an increase in homicides associated with family violence during lockdown (Bradbury-Jones and Isham, 2020).

DVA in BME communities in the UK

While the majority of victims are women and girls, not all experience DVA in the same way and not all face the same level of risk. For instance, BME women are more likely to suffer abuse not only at the hands of their partners, but also from multiple family members (Gill and Walker, 2020). BME women and girls also face greater barriers to accessing services (Femi-Ajao et al., 2020; Gill, 2011) and are also more likely to experience inappropriate

professional responses from statutory and voluntary agencies. This increased risk cannot, however, simply be explained by individual circumstances (e.g. lack of awareness of services), access to education (including language proficiency), the family/community context (e.g. a socio-cultural preference for sons, notions of 'honour' and 'shame'), or socio-economic factors (e.g. poverty, loss of educational and professional accreditation upon migration). The role of state policies (including service responses, immigration/welfare policies, funding regimes, and transnational legal regimes) also form a crucial 'conductive context' (Kelly, 2005) that can facilitate and/or sustain DVA in these communities.



Specialist DVA services catering for BME women (e.g. South Asian, African-Caribbean or Middle Eastern women) were established in the UK in the 1970s and '80s to tackle the hitherto unmet needs that arose from victims/survivors' location at the intersection of multiple forms of disadvantage. Such 'by and for' independent services are run by BME women who have an in-depth understanding of, and expertise in, the nature and forms of DVA within their communities, as well as of the

specific barriers that can prevent these women from accessing support. In 2020, specialist BME organisations faced unique challenges in supporting women and girls experiencing, or at risk of, DVA in a context where BME communities are disproportionately affected by the pandemic (Runnymede, 2020). For example, high level of multi-generational households, high level of underlying conditions that are especially dangerous vis-a-vis COVID, higher risk of death or serious illness with COVID, high level of employment in services that mean working from home is not possible (Public Health England, 2020; Qureshi, Kasstan, Meer and Hill, 2020).

Based on interviews with practitioners working in the sector, this briefing paper explores their experiences of the ‘double pandemic’ (Imkaan, 2020) – the spread of COVID-19 coupled with the subsequent rise of DVA in lockdown – and its impact on their organisations, the sector and the communities they serve.

Method

Semi-structured interviews were undertaken with a sample of 26 practitioners in specialist, independent DVA services in England and Wales (n=16) run ‘by and for’ BME women. Participants were recruited through the researchers’ existing networks via snowballing techniques. The key themes explored in the interviews concerned the nature and patterns of DVA during the pandemic, help-seeking behaviours and access to services, organisational responses to COVID-19, financial implications for services, and potential risks and remedies as the country emerges from the pandemic. Data collection took place between 30th October and 21st January 2020. All interviews were conducted on Zoom and were recorded with the express permission of the participants. Ethical approval was obtained from the Research Integrity and Ethics Committee at the Universities of Lincoln and Roehampton.

Research Findings

Impact of lockdown on DVA victims/survivors

Research carried out by Women’s Aid in June 2020 found that 61% of those surveyed (all participants were already experiencing DVA prior to the pandemic and living with their abuser) reported worsening of their abuse during the pandemic (Women’s Aid, 2020: 7).

The practitioners interviewed in this study observed the same escalation in both the prevalence and intensity of abuse within days of the first lockdown being announced in the UK in March 2020:

Even in the most awful circumstances, women could get a brief moment of respite by going to the shops, dropping their children off at school [...] Here it’s 24/7 you are imprisoned, and the psychological impact of that is much greater.

Lockdown also diminished opportunities for help-seeking from formal and informal sources of support. DVA organisations working with BME communities reported enhanced levels of psychological abuse and trauma-related mental distress. One organisation in the North East reported that:

Within days of lockdown, the first thing the women were telling us, what struck me, in the stories, was not so much the physical abuse that they were experiencing in lockdown, but the psychological abuse. [...] So [...] one woman said, ‘I don’t know how long the situation with the virus will last but I’m sure that it’s going to be difficult and very stressful for us. It is not obvious, the gaslighting and the crazy-making. I’ve reached a point like today when my hands are shaking during an argument, and I can’t stop it. I need your help to make this self-isolation bearable for me and my son’.

For women who had decided to end an abusive relationship prior to the lockdown, the pandemic delayed the separation process and the creation of separate households, prolonging the risk of ongoing DVA:

We had this woman call us and say, 'We are separated but still living under the same roof, as he refuses to move out. It was ok before because he would be out until late, but the COVID pandemic is causing more upset. He chooses when he wants to go out, putting my children and me at risk of catching the virus. [...] I'm trying to shield my children from it [COVID], but I can't'.

Practitioners across the sample reported that the abusers used lockdown restrictions and/or the risks of COVID-19 and its consequences as part of their abuse, reaffirming other research findings (Women's Aid, 2020). Several organisations interviewed also reported that enhanced risks of COVID-related job losses in the communities they serve were increasing the risk of DVA:

We have a significant percentage of our communities where the husbands, men in the family, are taxi drivers [...] they can't work. [...] Financially things are really tough. And I think people forget, in a household it could be a ticking time bomb.

BME workers are more likely to have jobs where fewer tasks can be performed remotely (McIntyre, Mohdin and Thomas, 2020); they are, therefore, more likely to experience reduced hours or job losses during lockdowns and, consequently, reduced earnings (Adams-Prassl et al., 2020). While some of the themes and enhanced risks highlighted above are common for women across the UK, the practitioners involved in this study reported that BME women were facing additional vulnerabilities that had been exacerbated by the pandemic.

Issues specific to BME victims/survivors of DVA during the pandemic

Although pandemic-related DVA in BME communities reflects broader patterns of DVA

escalation in terms of risk and intensity, there are also unique aspects of DVA specific to these communities, including particular forms of harm for which the pandemic has been a conducive context. The manager of a refuge service for South Asian women reported that

Many women have called to say, 'It's not just my husband now, it's my sister-in-law, my brother-in-law, my mother-in-law; they are kind of locked up in that same space, and the level of verbal abuse I'm getting, it just makes my mind blow up, and I just go in my bedroom, and I cry and I want to scream and bang my head on the wall, I really don't know what else to do'.

Several respondents noted the risks posed by school closures for girls at risk of forced marriage. The erosion of familiar routes to disclosure and support (such as private, in-person access to teachers and peer networks) is happening in a context where coercive pressures to marry can now be relentlessly exercised by multiple family members. An outreach worker for one organisation reported that

one of the things about other members of the family being involved in that threat [of forced marriage], it's almost like [...] they're working together to really break down that individual. [...] 'You're going to be', you know, 'no longer a member of this family, this is going to happen to you'. And that person actually believes that's going to happen to them because there's been no other moral compass, no one else in the family that supports what they want to do. So, this young woman called us; she was literally saying, 'there's no way out for me, if I don't do this [agree to the marriage], next year I'm going to not be allowed to go to college, and this is my only way out'.

Some forms of coercion deployed to break down resistance to forced marriage are rendered less visible during lockdown, meaning that perpetrators are able to escalate their abuse without attracting outside attention; for instance, usually a young person's absence from

school would result in contact from statutory services. As one interview participant reported

a young woman who contacted us [...] was self-harming; she was basically saying that because of lockdown now, her dad had used it as an excuse to lock her in the bedroom.

Lockdown also creates opportunities to conduct small weddings at short notice, ostensibly to avoid the impact of future, harsher lockdowns or to comply with existing restrictions on attendee numbers. Respondents from four organisations working with BME victims/survivors pointed out that the risks of forced marriage increased during lockdown because often only the smaller-than-usual family circle involved in the actual ceremony knew about the wedding and this minimised the possibility of referrals or investigations by third parties. As one advice worker from a BME specialist DVA organisation argued

You can end up having quite a lot of women being forced into marriage, as there's not much knowledge of what's going on [...] – that restriction allows you to have those weddings without making it public as usual.

In light of the limits on international travel during the pandemic, another respondent noted that the number of cross-border forced marriages could have fallen this year. However, the support worker for a different organisation anticipated a rise in transnational forced marriage as the pandemic recedes:

I think the FM [Forced Marriage] Unit needs to be more ready for responding to those cases. I think funding really needs to be available for having staff in place to be able to respond to those increases that will happen.

Women with insecure immigration status are amongst those who have been hardest hit by the pandemic. The particular difficulties facing women who are marriage migrants – many of whom come to the UK on spousal visas after

marrying a British national or resident – arise when they are given visas as dependants (during what is known as the probationary period), which means that their residence in the UK is tied to their marital status. Consequently, if their marriage ends, they could be deported and separated from any children. This threat is one of the many ways state policies on citizenship and residency exacerbate existing power imbalances between men and women.



Despite being underfunded and small compared with some of the larger generic service providers, BME organisations tend to help a disproportionate number of women with no recourse to public funds (NRPF): a pattern that has continued during the pandemic. These organisations report that women in this position face a stark ‘choice’ between living with violence or homelessness (Anitha, 2010):

It's hit hardest with migrant women with no recourse [NRPF], there's nowhere for those women to go. And in the context of COVID-19, when refuges were shutting

because they need to protect the residents in them, or because they couldn't move residents on, there was even less space for these women.

The director of the organisation spoke for several BME specialist DVA organisations when she observed that the denial of refuge spaces to women with NRPF has increased during the pandemic:

Our victims are being turned away from other refuges if they've got no recourse to public funding. XX [a member of a BME organisation] did a [...] call to one of the [generic] refuges, asked them if they had spare room for a woman with no recourse to public funds, they [the refuge] said no, and they [the same BME organisation] rang up again, with a white British name, lo and behold, a vacancy had come about. How bad is that?

Impact on BME/DVA specialist 'by and for' independent services

Representatives of all the organisations interviewed for this study noted that the increased prevalence of DVA across the communities they serve, and the heightened risk for those already in an abusive relationship, were exacerbated by additional barriers to help-seeking in the context of the pandemic and policy responses to it. Their organisations drew upon their experience of working and living within these communities to devise new ways of reaching out to vulnerable women and girls.

The outreach worker at one organisation in North West England recounted her conversation with a client she only managed to contact after several attempts:

We had a teacher who is worried this girl is being forced into marriage, and she was being sexually abused; there is a lot of control and coercion going on; we tried to get in touch with the girl, [...] but it was very difficult in the COVID situation, you know, in a five-minute phone conversation, we haven't heard

from her. [...] We are really letting her know her options, but for a young person locked away in these circumstances, trying to make that escape, it is going to be 10 times more harder [sic] to do.



Practitioners reported having to work harder to reach women and girls, including having to make themselves accessible by extending helpline opening hours or establishing new protocols to check on women's welfare to ensure their safety:

We're having to think about how we respond to women and the times that they need help; [...] one worker had to talk to a client about five or six times in a number of hours while she was running to the bathroom trying to make a quick call with the taps on; so, it's like having to be very flexible because that's the only opportunity they are getting to make those calls to us.

Mindful of young people's increased vulnerability to forced marriage, the director of one organisation recently established an alternate referral pathway:

Our usual mechanisms [...] are not going to work perfectly during COVID times. So things we will now be trying is a live web chat a couple of hours a day for young people to access our services.

Other innovative measures included meeting clients in the guise of a walk in the park:

With counselling, for example, staff are saying women are going out for a walk, and that's where they can have that session with us, because that's the only time they are going to be alone, or in the bathroom over the phone, wherever it is they are finding that space to do it. And then we are having to be flexible about things; for example, counselling for us has always been a 50-minute session, then the counsellor has 10 minutes for reflection and to make some notes; but now we are saying, if a woman rings she has 10 minutes, she has 20 minutes, we will allow that.

A majority of the organisations interviewed reported an increase in the number of referrals following an initial dip at the start of the first lockdown in March 2020:

We found that women held on until it was safe to make those calls, and to access that support, and then referrals have dramatically increased as time has continued. So the need is definitely there.

However, new modes of remote working do not meet the needs of women who struggle to access relevant technologies. There are also sometimes issues in establishing the level of trust needed for victims/survivors to make full disclosures when organisations are having to work purely online or over the phone. As one frontline worker at a small organisation observed,

A lot of people, from what I understand, don't like talking on a phone. It's not helpful. Not everyone wants to do a client conversation over Zoom. Face-to-face, I think, makes a huge difference; people are able to open up. I think we are missing out on a lot of victims here simply because it's just impossible to meet.

In some cases, barriers to accessing support during lockdown resulted in higher numbers of disclosures being made at a critical stage, as reported by the director of one organisation:

In the pandemic, what we tended to have was more disclosures at the point where things were moving towards the crisis level, but, because of the contained environments at the beginning of the lockdown – the restrictions of the schools, the colleges weren't open, and I'm making specific reference to young people [...] – that's where we've seen an increase. Where you are kind of a last resort.

One representative of a BME anti-violence organisation that supports women of African–Caribbean descent drew attention to the additional, race-based inequalities that have increased the demands on their services (“it’s kind of doubled our work”, she reported) during lockdown:

There's the obvious increase with the domestic abuse in general, and then you have the pandemic kind of paired with what some would call a race war with the whole Black Lives Matter movement, and everything that's going on. The two kind of can't be handled in isolation: they are interlinked. So that kind of distrust within the Black community, specifically where police have also been given more power [...]. So, over the lockdown period, I saw quite a few Black boys being stopped for no reason basically, or stopped when they are in groups of twos, threes, and their white counterparts haven't been stopped at all. [...] The whole kind of distrust with the police has been heightened, [...] this means we are less likely to report cases. You want your perpetrator to stop abusing you, you don't necessarily want him killed in police custody, or racially profiled, or abused, or deported. [...] So I think COVID has just kind of put more Black survivors or victims in more of a box, and almost in more danger because there's so many more elements now, especially being the most at-risk category [speaking about the rates of death from Covid].

For women who are unable to trust statutory agencies, including the criminal justice system, because of the history of institutional racism, stereotyping and a failure to meet the needs of their community, BME specialist DVA

providers may be their only source of advocacy, support and safety, as well as being the sole trusted pathway to statutory services.

During the first lockdown, understaffed and overstretched organisations expended their resources and staff time on negotiating service pathways to statutory services, or filling this gap where no such pathways existed. The director of one organisation reported that they were struggling to liaise with statutory agencies to meet clients' needs:

During COVID, staff had been responding to everything that came through. But it's also about managing the statutory agencies. There is only so much we can do, you know, as a charity; and we are having to fight a lot harder with housing. Domestic abuse was supposed to be a priority during COVID, and we've not seen that to be the case with housing from the local authority [...] Our advice service is also holding [on critical lists] women a lot longer because counselling services have shut down: mental health services, statutory agencies, they are all closed, so we are holding those cases.

Interviewees also noted the emotional toll of working through the pandemic without recourse to pre-tested mechanisms for support and recuperation. One refuge worker who was supporting several residents with complex needs reflected that

It's very, very difficult when you are doing this kind of work because if you think about being in an office, if you have a difficult conversation with a client, you've got your peers to kind of sit back and have a chat with or you've got your line manager – you know, you get quick debrief and get that support. That's no longer there.

While the pandemic has presented unique challenges for all third-sector organisations, those working on DVA, and especially BME specialist organisations, have had to respond to a double pandemic: COVID-19 and the increased prevalence of DVA, which often takes particular forms for BME women and girls.

Policy responses to DVA during the pandemic and the future of specialist services

The UK Government has been slow to anticipate and prepare for the surge in DVA during the pandemic. To fill this gap, the director of one DVA organisation recounted how they had created their own initiatives to address the urgent, unmet needs of victims/survivors:

We worked with [a cross-party social justice campaign group] and asked hotels to come forward and provide spaces for abused women. Many hotels and hostels did so on very subsidised rates, including [for] food. The government would not provide the funding. [...] Working with [a generic DVA organisation], we set up a scheme in London for over 130 women, some of which was for women with no recourse [NRPF]. [...] That's all on top of our usual work. Not instead of. [...] but we know if we didn't do any of those things, we would not be able to meet women's material needs on a daily basis.

During the COVID crisis, BME specialist DVA organisations have developed partnerships with wider community-based groups and generic DVA organisations, bringing together third-sector organisations and businesses to fund emergency measures for victims/survivors. However, their effectiveness should not mask the state's responsibility to address these basic needs.

In the absence of a robust governmental response, one of the organisations that participated in this study acted to hold the government to account:

They had done nothing, and we said [if] they had thought of street, homeless people, and had unlocked hotels, why aren't you doing the same for abused women? And I wrote a letter threatening legal action, and it was as a result of that letter that, two days after sending that, the day before a response was due, before we lodged proceedings in court, the government announced a

package for violence against women and girls, and that was because they were under threat of legal action.

Kelly Tolhurst (Parliamentary Under Secretary of State for Rough Sleeping and Housing) announced a £6-million Domestic Abuse Capacity Building Fund on 5th October 2020, enabling local authorities to rapidly commission support for DVA victims/survivors unable to be accommodated in refuges (Tolhurst, 2020). Local and national funding streams were also made available to [VAWG] organisations so that they could adapt their services to new modes of socially distanced working. This scheme benefitted several organisations that participated in this research but the short-term nature of the respite was noted:



One of the positive things has been obviously that there has been additional money available to services like ours [...] that have enabled us to be able to provide support to clients. [...] So that's been great, yeah? But on the other hand, it's about the longevity of this. [...] We are seeing an increase in presentation of survivors to services. [...] We are having to think about having

a pause in taking referrals, because we literally don't have the capacity anymore to process them. [...] We can't refer them on anywhere, because pretty much everywhere has got a closed waiting list.

The pandemic has brought the financial insecurities of small, independent BME specialist DVA organisations into sharp relief at a time when the demand for their services has been ever-increasing in what one respondent described as a "tsunami of cases". Yet year-on-year budget cuts since 2010 have led local authorities to search for savings, and an easy target seems to have been BME specialist DVA services.

The director of one affected organisation took stock of the challenges facing them and the wider BME specialist DVA sector:

We struggled, even prior to the pandemic. [...] We try to be a holistic service provider, so that women aren't going from place to place. Language is just one part of it, you know? It's just one added thing. But one of the things we've seen prior to the pandemic is the generic organisations are delving into this specialist work saying, 'We can do this, and we can do that too'. And they are bidding for services that are specialist. And they are getting the contracts. So it's a huge issue for us.

As local authorities seek economies of scale, they are increasingly tendering their refuge spaces to providers (such as housing associations) that have never worked in the violence against women sector and may not offer women-only spaces. As one interviewee said,

When I started work in this sector, a BME organisation was called a specialist organisation, but now the generic Women's Aid organisation, it is a 'specialist' organisation, and housing associations are not a specialist organisation. So the whole terminology has changed to erase our existence: the rationale for our existence [...].

Another respondent explained how her organisation has responded to this misapplication of the term 'specialist':

Now we tend to describe ourselves as 'by and for' services because they can't really take that away from us, you know what I mean? It's really important for us to say 'by and for' [BME women] because they are using all the terms of intersectionality [...].

This study (and other research) demonstrates that BME women are more likely to approach BME specialist services for help, as these are the spaces they trust because they feel safe, understood and less alone there (EVAW, 2015: 4; Imkaan, 2020). This finding clearly illustrates the need for a diversity of service providers, including small, independent providers that offer specialist support and knowledge. If these organisations no longer exist, numerous at-risk women and children may never receive the help and support they need.

To keep them safe, BME women often have to be housed in refuges far from home because local community networks may otherwise expose their location to perpetrators. For this reason, refuges for BME women are frequently located in local authorities that do not have a significant BME population. However, these refuges have sometimes been closed on the basis that they do not meet local need, even though they were always intended to meet a *national* need that can only be served in this way. The Domestic Abuse Bill 2020 fails to address the fact that current funding regimes are eroding specialist services, as a senior worker at one organisation reported:

It's the same issue with the Domestic Abuse Bill, [...] part 4 is focused on how refuges will be funded in the future, and again we are like, 'don't let local authorities decide on specialist refuge provision because they are going to just say, "Well, it doesn't meet the local need. It's got to be a nationally, or a regionally funded provision."' Now, whether they listen to that [interviewee sighs] [...] and, if they don't, I see the long-term outlook is just not surviving, to be honest.

Several practitioners recommended that the Ministry of Housing, Communities and Local Government's strategy for funding the third sector should ring-fence resources for DVA services more broadly and, within that, for BME specialist DVA services in particular.

There are also other gaps in the Bill that fail to address the needs of women with NRPF, who are often supported by BME specialist DVA services. Despite campaigning from BME organisations, opposition MPs and mainstream charities, MPs voted 330 to 207 against a proposed Clause 22 of the Domestic Abuse Bill 2020 to lift the NRPF rule for migrant women experiencing domestic abuse (The Public Whip, 2020).

Policy making needs to better address the needs of BME and migrant women and the organisations that support them during and beyond this pandemic.

Conclusion

This briefing explores how BME specialist DVA services have responded to the pandemic's gendered impact on the communities they support, including in relation to the exacerbation of DVA generally and specific forms in particular, as well as the additional barriers to accessing help and support that have resulted from lockdown and social distancing.

Frontline practitioners, health professionals, and the police are overworked and understaffed; local counselling support groups are either paralysed or financially deprived. In some cases, women from BME communities do not trust statutory agencies, including the criminal justice system, due to negative prior experiences. In this context, 'by and for' BME specialist, independent DVA services perform a crucial role in supporting victims/survivors from communities that are already

disproportionately affected by the pandemic. Despite strong evidence of the need for specialist services, underfunding and cuts have resulted in the erosion of this sector over the last decade. As plans are made for life beyond the pandemic, these services must be included in the creation and design of both future social support networks and statutory services; moreover, this should be done in collaboration with victims/survivors to ensure their voices are heard and their real needs met.

Victims/survivors' economic safety must be guaranteed and the social support available to them extended through proper access to secure housing and welfare services. The UK Government urgently needs to engage in transparent decision-making that fosters equity in the distribution of expenditure, including to 'by and for' independent, specialist DVA services.

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