Intersectional Risk Tracker Tool

The Intersectional Risk Tracker Tool for Domestic Abuse: A Comprehensive, Survivor-Centred Approach to Safety Planning

Intersectionality is not primarily about identity, it's about how structures make certain identities the consequence of the vehicle for vulnerability.

Kimberle Crenshaw

Intersectional Risk Tracker Tool

This tool provides a holistic framework for exploring how intersecting identities, marginalisation, and life experiences influence a victim-survivor's unique risks, barriers to safety, and needs.

Our tool enables professionals to foster more inclusive, trauma-informed discussions with survivors and offers a means to track risk levels and intervention effectiveness. It also serves to enhance life-saving risk assessments by inviting deeper understanding and cultural humility in recognising how intersectional marginalisation can intensify abuse.

The IRTT is designed for flexibility and can be adapted to suit diverse victim-survivor demographics, including those often overlooked in traditional risk assessment tools - such as migrant women, racially marginalised women and individuals with diverse gender identities and sexual orientations.

Our tool empowers professionals to deliver more inclusive, accessible, and effective services. It is constructed to complement existing best practices, rather than to replace tools like the DASH risk assessment.

Our recommendation is that this tool be used only after completing our training programme. This is to ensure that it is used responsibly and effectively, and that users are equipped to respond appropriately to the complexities of intersectional risk in domestic abuse.

Contact us at wearefrieda.org.uk or email us at talkto@wearefrieda.org.uk for more information.

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Note on Language:

Every act of abuse, irrespective of its nature, is severe and represents a serious violation of human rights. When we categorise abuse as 'low risk', 'moderate risk', or 'high risk', it's not to downplay the severity or the damaging impacts of 'low risk' forms of abuse. Rather, these categories are used as a tool for professionals to assess and track the situation, and to guide the necessary response in terms of support and intervention.

The 'risk' here refers not to the legitimacy or severity of the abuse itself, but to the potential escalation of the abuse and the immediate physical and emotional safety of the survivor. 'High risk' typically signifies that immediate and assertive interventions are necessary due to the likelihood of severe harm or life-threatening danger.

However, we know that every experience of abuse is valid, and even 'low risk' situations can have devastating and long-lasting impacts on the individual. No level of abuse is acceptable, and every person deserves support, respect, and safety.

These classifications are designed to help provide the most effective support and intervention for people in different situations. They are not intended to minimise or invalidate any experiences of abuse. We must approach each case with empathy, respect, and an understanding of the unique intersectional factors influencing the overall risk and need.

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User Note: Intersectionality within the Matrix of Domination:

The factors within the IRTT, ranging from 'Honour'-Based Abuse to the impacts of cultural stereotypes, operate within the broader framework of the matrix of domination, where intersectionality is key to both understanding and response. None of the factors don't exist in isolation but rather interact with, influence, and exacerbate each other, contributing to a complex web of discrimination and abuse that is rooted in the larger macrosystem of structural violence.

When assessing the risk and impact of abuse, we have to consider both the microsystem, individual and immediate social environments, and the macrosystem, including societal, cultural, and institutional structures that perpetuate inequality and violence. This helps us ensure a more accurate understanding of the survivor's experience and the multifaceted nature of abuse.

Advocacy and intervention strategies must therefore extend across all parameters, addressing immediate needs and challenges within the microsystem while also challenging and seeking to change the structural inequalities within the macrosystem that underlie and perpetuate abuse.

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User Note:

 Use survivor voice alongside scoring. Practitioners complete the Low / Medium / High assessment, while also supporting survivors to describe how they experience that factor.

 Each factor includes a space for "Survivor Voice." Here, survivors' own words, reflections, or concerns should be recorded.
  - Example: "He always hides my medication; I worry most about my health."
  - Example: "I don't think the racism at work is as big a problem as the threats he makes when I try to leave."

Survivors can highlight which risks feel most urgent or unsafe to them, even if the professional rating differs. Survivors may also indicate their confidence in their safety plan (e.g. rating 1–5), giving practitioners a way to measure changes in survivor wellbeing over time. When re-assessing, survivors should be actively included in reviewing whether identified risks have increased, decreased, or changed in nature. Survivor voice must meaningfully influence safety planning, advocacy, and decision-making. Practitioners are encouraged to use the survivor's priorities as the foundation for intervention strategies, while still applying professional judgement to manage urgent safeguarding risks.

Measurement:

Each intersectional factor in the IRTT is scored on a simple scale:

- Low (1) → minimal or no evidence of risk in this area.
- Medium (2) → some evidence of risk, occasional behaviours, or barriers that complicate safety.
- High (3) → clear or systematic behaviours/barriers that significantly endanger safety, wellbeing, or autonomy.

Practitioners mark one level for each factor based on evidence, survivor voice, and professional observation. The purpose is not to generate a total score but to show you where to focus your case management and safety planning. Patterns of Mediums and Highs highlight where risks are accumulating, where barriers need to be addressed, and where advocacy is most urgently required.

Interpreting Scores:

- Scores may show patterns but they can't and won't show absolutes, the numbers help us highlight and monitor where risk accumulates, to support our case management but they cannot always capture the intensity of risk or the interactions between different factors. We have to remember risk is not a fixed number, instead it changes with context, escalation, and intersection.

- Narrative scoring is as important as numbers. Practitioners should record what the scores mean in context, for example how factors combine, what the survivor says feels most unsafe, and what barriers are most urgent.

- Professional judgement matters. Practitioners can and should override or elevate risk ratings where their expertise or safeguarding duties indicate higher danger than the numbers suggest. For example, certain indicators (strangulation, reproductive coercion, multiple perpetrators, imminent FGM, threats to kill) immediately elevate the case to High Harm and High Risk and appropriate actions must be taken.

- Survivor voice is central. A survivor's sense of fear or escalation may reveal risks not yet visible in formal scoring and must always be given weight.

Remember

This tool is not designed to replace the DASH risk checklist or to act as a direct referral mechanism for MARAC. Unlike DASH, which is primarily used to identify imminent high-risk cases for multi-agency escalation, the IRTT has a different function.

- It is intended to run alongside case management and has longevity, it can be revisited and updated over time as circumstances change.

- It is designed to open conversations with survivors and practitioners about a wide range of intersectional risks that may not be captured in traditional tools.

- It highlights the factors that influence safety planning and advocacy, particularly structural barriers and systemic inequalities.

- It is a supportive companion to the DASH, deepening the understanding of risks, context, and survivor needs, it strengthens the overall quality of risk assessment, case management, and advocacy.

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WORKING TOOL

The Short Version is a practical assessment tool for frontline use. It condenses each factor into simple Low/Medium/High descriptors with space for Survivor Voice and Practitioner Notes. This version is intended for use during live assessments, safety planning, and case discussions, helping you record risk levels quickly while still centring the survivor's voice.

PRACTITIONER GUIDE

The full Practitioner Guide will give you detailed explanations of each intersectional risk factor, examples of behaviours, systemic barriers, and provide space for practitioner notes. It is designed as a reference and training tool, supporting you to deepen your understanding of intersectional risks and strengthen your professional judgement. It offers context, notes, and guidance for culturally competent and trauma-informed practice.

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Intersectional Factor	Low	Medium	High	Survivor Voice	Practitioner Notes/Score
Separation-Instigated Abuse	No change	Some increase/control	Stalking/threats/violence		
Economic & Cost of Living	Stable income/benefits	Partial dependence/unstable	Full dependence/homeless risk		
Children as Victims	Not involved *(rare)*	Occasional involvement	Systematic involvement/harm		
Physical Health & Injuries	No injuries/competent care	Some injuries/inconsistent care	Severe injuries/missed on darker skin		
Healthcare & Discrimination	Equitable care	Occasional bias/delay	Frequent/systemic discrimination		
Pregnancy & Maternity	Safe, supported care	Disrupted/surveillance	Targeted violence/repro coercion		
Sexual & Reproductive Health	Safe access/respected	Stigma/partial control	Repro coercion/denial of care		
Sexual Exploitation & Violence	Safe, consensual	Compromised autonomy	Ongoing SV/sex work survival		
Mental Health	Coping, no major needs	Anxiety/depression; some manipulation	Severe/chronic; targeted vulnerabilities		

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Substance Use	No use/not exploited	Occasional use/manipulated	Chronic/forced/sabotaged treatment		
Social Factors	Strong support	Limited support; some discrimination	Severe isolation/discrimination		
Cultural Considerations	Culture supports safety	Some barriers/stereotypes	Honour/shame weaponised		
Religious Considerations	Faith supports safety	Expectations complicate	Doctrine/authority weaponised		
Safety Planning	Plan complete/cultural fit	Partial plan/barriers	No workable plan		
Racial & Ethnic Identity	Respected/no discrimination	Some discrimination	Systemic racism exploited		
Fear of Discrimination in Help-Seeking	No fear; inclusive services	Fear delays access	Fear blocks access		
Age & Life Stage	Stable resources	Transition/stereotypes increase vulnerability	Dependency exploited		
Chronic Illness & Disability	Needs met	Some barriers/minimising	Withheld care/targeted harm		
Neurodivergence	Recognised/accommodated	Dismissed/unsupported	Weaponised/denied support		
Gender ID & Sexual Orientation	Affirmed/inclusive	Bias/misgendering/outing	Systematic targeting/violence		

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Immigration & NRPF	Secure status/full access	Uncertain/partner-dependent	NRPF/threats/deportation		
Systems & Criminalisation	Supportive/neutral	Mixed/bias limits trust	Profiling/unjust criminalisation		
Professional Intersectionality	Strong awareness	Inconsistent	Unrecognised/unsafe practice		
Tech Use (Migrant Survivors)	Safe access/overseas ties	Some monitoring/restrictions	Heavy control/denial		
Language & Communication	Fluent/no barriers	Some barriers/informal interpreters	Minimal proficiency/exploitation risk		
Cultural & Societal Stereotypes	No stereotype harm	Occasional bias	Systematic controlling images		
FGM/C	No risk; strong safeguarding	Indirect pressure/travel risk	Imminent/strong pressure		
Honour-Based Abuse	No threats	Occasional shame/ostracisation	Multiple perps/forced marriage/violence		

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Intersectional Factor	Low Risk	Medium Risk	High Risk	Survivor Voice	Practitioner Voice
Separation Instigated Abuse	No escalation in abusive behaviour following separation. Patterns of behaviour remain consistent with no significant changes.	Abuse intensifies following separation. Tactics may include increased control, emotional manipulation, indirect threats, or attempts to maintain influence through coercion and manipulation. Post-Separation Abuse Wheel	Abuse escalates significantly after separation, with behaviours such as stalking, direct threats, physical aggression, or harassment. These actions are intended to intimidate, cause harm, and exert control, with serious impact on safety and wellbeing.		
Economic Factors & Cost of Living Crisis	Financial independence is maintained through stable employment and secure housing. Welfare benefits are fully accessible if required, and the cost of living crisis has little or no adverse impact. Stability in income and resources supports autonomy and the ability to meet needs.	Partial financial dependence is present, alongside unstable employment or housing. The cost of living crisis exacerbates pressures, and economic instability creates opportunities for control through financial coercion. Barriers such as delays in benefits,	Complete financial dependence is evident, with no personal income and/or a significant risk of homelessness. The cost of living crisis entrenches this dependency. Economic vulnerabilities are systematically targeted through denial of benefits, misuse of		

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		sanctions, or restricted access further heighten vulnerability. Tactics such as benefit fraud, withholding payments, or manipulation of claims may be used to maintain control. Economic Abuse Wheel	welfare systems, or deliberate restriction of financial access. Such tactics intensify isolation, coercion, and control, severely undermining autonomy and access to safety.		
Children as Victims	No children involved. Children are not 'directly' exposed to abusive behaviours, and there is no evidence of involvement in dynamics of coercion or control. Their wellbeing, relationships, and sense of safety appear unaffected. *Note: Where children are present in a household affected by domestic abuse, it is unlikely that they are not co-victims in some way. Even limited exposure may still impact emotional wellbeing and development and must be considered within safeguarding responses.*	Children are occasionally drawn into dynamics of abuse, with the parent–child relationship used to apply pressure. Tactics may include threats, disputes over custody, or using children to pass messages. These behaviours create a tense and harmful environment for both the parent and the children. *Children in these circumstances must be recognised as co-victims and require appropriate, specified risk assessment and safeguarding responses.* Abuse of Children Wheel	Children are frequently and systematically used within abusive behaviours. Examples include direct threats of harm, use of children as leverage in disputes, or manipulation of contact arrangements as a mechanism of control. These tactics profoundly affect emotional wellbeing and decision-making, making it more difficult to seek help or leave the abusive situation, while simultaneously causing direct harm to the children. *Children in these circumstances must be recognised as co-victims and require appropriate,*		

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		Children's Domestic Abuse Wheel	*specified risk assessment and safeguarding responses.*		
Physical Health Status & Recognition of Injuries on Different Skin Tones	No significant injuries are present, and consistent access to healthcare is available. Health professionals demonstrate awareness of how injuries present across different skin tones, supporting accurate recognition and timely care.	Some injuries are visible or reported, but access to healthcare is inconsistent. Difficulties arise in recognising injuries across different skin tones, which can delay or complicate treatment. Harm may be directed towards areas less likely to show visible signs, or existing health conditions may be aggravated in subtle ways. Project Archway – Better capture bruising on darker skin	Multiple or severe injuries are present alongside restricted or limited access to healthcare. Injuries on darker skin tones are frequently misidentified, minimised, or overlooked, enabling harm to remain hidden. Serious health conditions may be deliberately exploited or weaponised, with denial of treatment or targeted injury increasing risk to life and wellbeing.		
Healthcare and Discrimination	Healthcare access is consistent, culturally competent, and free from discrimination. Services are responsive to different identities, skin tones, languages, and needs, ensuring equitable treatment.	Barriers or discrimination are occasionally experienced in healthcare. This may include stereotyping, dismissive attitudes, delays in treatment, or inadequate consideration of cultural and intersectional needs. These experiences may discourage timely engagement with health services.	Discrimination within healthcare is frequent and systemic, severely limiting access to safe and effective treatment. Patterns may include racial bias in pain management, misdiagnosis linked to skin tone or cultural assumptions, and refusal or withdrawal of care. Such experiences		

			reinforce mistrust of healthcare systems and compound health risks, leaving survivors without essential medical support.		
Pregnancy and Maternity	Pregnancy is supported with consistent, non-discriminatory healthcare. Maternity services are accessible, trauma-informed, and culturally responsive. No abuse is directed towards pregnancy, and there are no restrictions on antenatal care or postnatal support.	Pregnancy is accompanied by inconsistent or disrupted access to care. Barriers may include missed appointments due to controlling behaviours, limited support networks, or discriminatory attitudes from healthcare providers. Pregnancy may be used to increase surveillance, limit choices, or exert pressure in subtle ways (e.g. restricting rest, controlling medical decisions).	Pregnancy significantly increases vulnerability. Behaviours may include physical violence targeted at the pregnancy, coercion around reproductive choices, denial of antenatal or postnatal care, or interference with maternal health. Discrimination within healthcare, including racial bias in maternity outcomes, compounds risk. Such conditions severely endanger both maternal and infant health and highlight urgent safeguarding needs. *Note: Reproductive coercion in control of contraception, forced pregnancy, pressure to terminate, or denial of*		

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			reproductive choices. Multiple back-to-back pregnancies repeated or closely spaced pregnancies used as a mechanism of control, with serious implications for physical and emotional health.		
Sexual and Reproductive Health	Access to sexual and reproductive healthcare is consistent and safe. Choices around contraception, sexual health screening, and reproductive decisions are respected and supported without interference. No cultural and/or religious factors hindering access to sexual and reproductive healthcare.	Sexual health is undermined by inconsistent access to services, stigma, or partial control over reproductive decisions. Behaviours may include pressure around contraceptive use, shaming linked to cultural or gender norms, or restricted access to sexual health services. Discrimination or discomfort in healthcare settings may discourage disclosure and treatment.	Sexual and reproductive health is deliberately targeted or systematically controlled. This may include reproductive coercion (e.g. enforced pregnancy, forced abortion, contraception sabotage), denial of sexual health care, or harm through untreated or deliberate and forced exposure to sexually transmitted infections. Structural inequalities, cultural stigma, and healthcare discrimination intensify risk, leaving sexual health needs unmet and autonomy profoundly undermined.		
	EXAMPLES OF CULTURAL AND RELIGIOUS BARRIERS TO SEXUAL & REPRODUCTIVE HEALTH				

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	• **Stigma around sexuality:** Cultural or religious norms that shame sexual activity outside of marriage can prevent survivors from seeking contraception, sexual health screening, or STI treatment. • **Restrictions on contraception:** Beliefs that contraception use is sinful, against religious teachings, or only appropriate after childbirth. • **Virginity and honour norms:** Fear of being "discovered" as sexually active or not a virgin can discourage survivors from disclosing sexual abuse or accessing reproductive healthcare. • **Taboos on discussing sex:** Cultural silence around sexual health can stop survivors from even naming their needs, let alone seeking care. • **Reproductive expectations:** Pressure to have many children, particularly sons, can normalise reproductive coercion or limit choice around family planning. • **Religious gatekeeping:** Leaders or family members discouraging use of sexual health services or urging prayer/forgiveness instead of medical or safeguarding intervention. • **Gender roles in healthcare:** Expectations that only male or female providers are acceptable, creating barriers if survivor preference cannot be met. • **Mistrust of services:** Historical or ongoing racism, cultural stereotyping, or lack of culturally competent care leading to fear of judgement, dismissal, or breaches of confidentiality. • **FGM/C norms:** In some communities, Female Genital Mutilation/Cutting is upheld as a cultural or religious expectation, directly impacting reproductive and sexual health. • **Abuse of modesty norms:** Coercion framed as protecting modesty e.g. denying gynaecological exams or sexual health screenings. • **Purity culture:** Emphasis on sexual abstinence and "moral purity" as a measure of worth can silence disclosures of sexual violence, discourage survivors from seeking care, and frame survivors as "responsible" for abuse if their purity is deemed compromised.				
Mental Health Status (including Racial Trauma and Minority Stress)	No significant mental health needs are present. Safe and effective coping strategies are in place and protective. Experiences of racial trauma or minority stress are	Signs of mental health needs such as anxiety, depression, or difficulty managing stress are evident. Experiences of racial trauma or minority	Severe or chronic mental health needs are present, including complex PTSD, major depression, or chronic anxiety. Clear and sustained effects of racial		

	minimal or not currently affecting daily functioning.	stress contribute to emotional strain. Manipulation may occur through the exploitation of mental health challenges or racial trauma, with psychological control and coercion undermining resilience.	trauma or minority stress are evident, compounded by inadequate access to culturally competent mental health support. Gaslighting, coercion, or isolation may be reinforced through deliberate targeting of mental health vulnerabilities and racial trauma, significantly restricting the ability to seek support or recover.		
Substance Use	No history of substance use is present. Daily life is not impacted by dependency, and there are no indications of substances being used as a tool within abusive dynamics.	Occasional substance use occurs but does not reach a severe or chronic level. Patterns of control or coercion may involve the introduction, encouragement, or manipulation of substance use. These dynamics complicate wellbeing and autonomy, even if immediate physical harm appears limited.	Chronic and severe substance use is evident, significantly impairing health, judgement, and capacity to seek help or exit unsafe situations. Substance use is systematically exploited as a tool of control, manipulation, and isolation. Restriction of treatment access, deliberate enabling of dependency, or weaponisation of addiction deepens harm and severely undermines recovery efforts.		

	Note: Substance use can manifest in many ways beyond dependency. It may involve coercion to obtain or use substances, transactional sex or survival sex linked to substance access, or targeted behaviours that exploit addiction. Stopping or starting substances can also act as a catalyst for abuse, where recovery efforts, relapse, or withdrawal become points of escalation. These dynamics are not **neutral,** they intersect with race, gender, gender identity, and sex, meaning that substance misuse and exploitation can compound existing marginalisation. Practitioners should avoid assumptions about choice, agency, or morality when substance **use** is present in abusive contexts. Red flag indicators include: • Forced substance use. • Coercion into procuring substances. • Pressure into sex work linked to substance access. • Withholding or sabotaging treatment, detox, or recovery support. • Escalation of abuse when substance use is stopped or started, with behaviour changes used as a trigger for control or violence. • Racial stigma as a treatment barrier				
Sexual Exploitation and Violence	Sexual activity and relationships are safe, consensual, and free from coercion. There is no evidence of sexual exploitation, transactional/survival sex, or sexual violence. Access to sexual and reproductive healthcare is consistent, and sexual autonomy is respected.	Signs of compromised sexual autonomy are present. This may include occasional survival or transactional sex linked to financial hardship, housing insecurity, or substance use; pressure or coercion around sexual activity, including within intimate relationships; limited or delayed access to sexual healthcare due to stigma or fear of disclosure; or isolated incidents of sexual violence that are	Sexual activity is frequently non-consensual, coerced, or exploitative. Patterns may include ongoing sexual violence, coercion into sex work or exploitation within sex work, reliance on survival sex as a primary means of meeting basic needs, or sexual violence compounded by other abuses such as reproductive coercion, substance misuse, or housing precarity. These		

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		minimised or unreported. These dynamics create vulnerability and reinforce harmful power imbalances.	conditions severely undermine autonomy, safety, and health, with long-term consequences for wellbeing and recovery, and require immediate safeguarding and specialist sexual violence support.		
Social Factors	A strong support network is in place, providing consistent connection and belonging. Experiences of discrimination are minimal, and social relationships create resilience against isolation. This foundation of support offers protection from abusive dynamics and fosters stability.	Social support is limited, and occasional discrimination undermines confidence and sense of belonging. Isolation tactics may weaken existing networks, while societal prejudice erodes trust in others. These pressures make it harder to sustain relationships and increase vulnerability to control.	Isolation is severe, with little or no support network available. Discrimination is frequent and compounded by social norms or stereotypes that reinforce exclusion. These conditions are exploited through manipulation and coercion, leaving people highly vulnerable. Constant exposure to bias and isolation has a serious impact on mental health and reduces the ability to seek help or maintain autonomy.		
Cultural Considerations	Cultural identity and practices are a source of strength and belonging. Community connections and	Cultural expectations occasionally create hesitancy or barriers to seeking help. Experiences	Cultural dynamics present significant barriers to safety. Honour, shame, or family reputation may be		

	cultural norms provide support and do not limit access to services or safety. Culturally competent resources are available and accessible.	of racism or cultural stereotyping in services may discourage disclosure. Norms around family roles, honour, or gender may be invoked to delay or complicate decision-making. Access to culturally appropriate services is limited or inconsistent.	weaponised to enforce silence, restrict options, or prevent disclosure. Community pressures may result in rejection or isolation. Lack of culturally competent services compounds risk, leaving limited pathways to support or protection. Cultural Power and Control Wheel		
Religious Considerations	Religious beliefs and practices are a source of resilience and community connection. Faith-based resources are supportive and accessible, aligning with safety and autonomy.	Religious expectations occasionally restrict autonomy or complicate decision-making. Beliefs may be invoked to discourage help-seeking or pressure survivors to maintain relationships despite harm. Supportive faith-based resources exist but are inconsistent or underused due to fear of judgement	Religious doctrine or authority figures are actively used to justify abuse, enforce obedience, or prevent disclosure. Survivors may face threats of ostracisation from faith communities, denial of spiritual belonging, or pressure to forgive rather than seek protection. Where faith-based services are the only option, lack of inclusivity or safety can severely limit access to meaningful support.		

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			<u>Christian Power and Control Wheel</u>		

Note

Culture and religion are often discussed together, but they are not the same thing. Each can act as a protective factor that offers identity, resilience, and belonging, or as a barrier when weaponised to restrict autonomy, enforce silence, or discourage help-seeking.

- Culture refers to shared practices, traditions, values, and social norms within a community. It can shape expectations around family roles, gender, honour, shame, and belonging.
- Religion refers to systems of faith, belief, and spirituality. It can provide comfort, community, and guidance, but can also be misused through doctrine, authority, or pressure from faith leaders or congregations.

Separating these two factors ensures they are assessed independently. This avoids conflating cultural practices with religious beliefs and helps to identify both unique risks and unique sources of strength. Practitioners should explore with survivors how culture and religion interact in their lives, always recognising that both can simultaneously provide support and be exploited as tools of control.

| Safety Planning and Cultural Barriers | A comprehensive and adaptable safety plan is in place. Cultural background is respected within the plan, and no cultural barriers interfere with its design or implementation. Planning is inclusive, practical, and supports both safety and independence. | Safety planning is partially developed but complicated by cultural barriers. Expectations around family roles, honour, gender, or community belonging may limit available options or make separation more difficult. These cultural dynamics can be exploited to disrupt or weaken | No safety plan is in place, or cultural barriers significantly obstruct efforts to prepare or act. Norms around obedience, family reputation, or community standing may be weaponised to prevent disclosure or restrict help-seeking. These barriers, reinforced by isolation or lack of culturally competent services, leave | | |

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		safety strategies, leaving gaps in protection.	few viable pathways to safety and autonomy.		
Note: Cultural identity can provide strength, belonging, and protective networks, but it can also present barriers when weaponised within abusive dynamics. Practitioners should not assume culture is automatically a risk factor. Instead, they should explore with survivors how cultural expectations, community dynamics, and systemic discrimination shape both barriers and opportunities for safety planning. Examples of cultural barriers to safety planning include: • Honour and shame norms that discourage disclosure or leaving a relationship. • Community or family pressure to reconcile, forgive, or "keep problems inside." • Gender role expectations that limit autonomy in decision-making. • Fear of ostracisation or gossip within close-knit communities. • Language barriers and lack of culturally competent services, making plans less accessible or safe. • Distrust of systems due to racism, stereotyping, or prior negative experiences, reducing confidence that plans will be supported. • Collectivist norms that prioritise family or community needs over individual safety, making separation or disclosure more difficult.					
Racial and Ethnic Identity	Racial or ethnic identity is respected and not a source of discrimination within daily life. Biases are minimal or actively challenged, and identity can be expressed without fear. Experiences of abuse do not exploit race or ethnicity as a mechanism of harm.	Occasional discrimination is experienced in community, services, or institutions. Harmful stereotypes or prejudices may be invoked to belittle or isolate, undermining confidence and sense of belonging. These dynamics can increase vulnerability and limit trust in support systems.	Discrimination based on race or ethnicity is frequent and deeply embedded. Racism, prejudice, or cultural stereotypes are systematically exploited within abusive dynamics to demean, isolate, or control. The compounded effect of structural racism and interpersonal		

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			targeting magnifies marginalisation, limits safe access to services, and reinforces barriers to protection and recovery.		
Fear of Discrimination Based on Racial Identity in Help Seeking	No fear of racial discrimination when engaging with services. Support systems are perceived as inclusive, culturally competent, and responsive to diverse racial and ethnic backgrounds. Confidence in accessing help is high.	Concerns about racial discrimination are present and may delay or complicate help-seeking. Fear is shaped by personal experiences, community narratives, or awareness of bias within systems. These concerns can reduce trust in professionals and discourage early engagement with support.	Significant fear of racial discrimination strongly restricts or prevents access to help. Anticipated racism, rooted in lived experience or systemic patterns, creates a sense of isolation and helplessness. Real or perceived bias in services reinforces mistrust, leading to withdrawal from formal support and increased vulnerability.		
Age and Life Stage	Age and life stage do not present significant vulnerabilities. Resources, autonomy, and social support are in place, reducing the likelihood of age being exploited. Support networks and access to services help buffer against isolation or dependence.	Life stage or age-related factors occasionally create dependency or increase vulnerability. Transitions such as entering parenthood, major career changes, or retirement can be leveraged to limit autonomy. Health needs, financial pressures, or stereotypes linked to age may also be invoked to	Age or life stage is systematically exploited to exert control or create isolation. Older adults may face withholding of care, financial exploitation, or neglect, while younger people may face restricted autonomy, lack of resources, or heightened risk due to inexperience. Across ages, dependency linked to health, finances,		

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		undermine confidence or restrict access to support.	or care needs may be weaponised, severely impacting safety and decision-making.		
Chronic Illness and Disability	Chronic illness or disability is either not present or does not significantly affect daily functioning. Healthcare is accessible and responsive, with no evidence of discrimination or barriers to treatment. Autonomy is maintained, and support needs are met.	Chronic illness or disability impacts some aspects of daily life. Barriers to healthcare or accommodations occasionally arise, including dismissive attitudes, stereotyping, or delays in treatment. Illness or disability may be minimised or used to undermine confidence, increasing stress and dependence.	Chronic illness or disability is significantly exploited, leading to heightened control, isolation, or harm. Tactics may include withholding medication, restricting mobility aids, denying access to care, or directly targeting health vulnerabilities. Discrimination in healthcare settings and lack of accommodations compound risk, severely undermining independence, wellbeing, and access to safety.		
Neurodivergence	Neurodivergent traits are either not present, or where they are, they do not significantly affect daily life. Supportive networks and accessible services are in place, and neurodivergence is recognised and accommodated without stigma.	Neurodivergence creates some challenges in daily life, including barriers to accessing culturally competent or neuro-affirming support. Traits may be minimised, pathologised, or used to undermine confidence. Manipulation can occur	Neurodivergence is significantly exploited, becoming a central mechanism of control and isolation. Patterns may include gaslighting, silencing, or weaponising traits to question credibility. Support is actively withheld,		

		through dismissal of needs, misrepresentation of behaviour, or restricting access to therapy, adjustments, or accommodations.	misinterpreted, or denied, while systemic barriers, such as lack of neuro-affirming services, compound risk. These conditions severely impact autonomy, mental health, and capacity to seek or sustain help.		
Gender Identity and Sexual Orientation	Gender identity and sexual orientation are affirmed and respected within personal, community, and service contexts. Support systems are inclusive, and there are no indications of coercion, discrimination, or exploitation linked to identity. Safety and autonomy are upheld.	Discrimination or bias is occasionally experienced in relation to gender identity or sexual orientation. Harmful behaviours may include misgendering, ridicule, threats of "outing," or invoking stereotypes. These dynamics increase vulnerability, create isolation, and may discourage engagement with services due to fear of judgement or breach of confidentiality.	Gender identity and sexual orientation are systematically targeted as mechanisms of harm. This may include persistent misgendering, coercion through threats of "outing," denial of gender-affirming care, exploitation of internalised stigma, or direct violence rooted in homophobia or transphobia. These behaviours severely undermine autonomy, erode safety, and compound systemic barriers to accessing respectful and effective support.		

Note:

Gender identity and sexual orientation are distinct aspects of identity and should be explored separately:

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- Gender identity relates to a person's internal sense of self and how they experience and express gender.
- Sexual orientation relates to patterns of emotional, romantic, and/or sexual attraction.

While these identities are different, they can also intersect in ways that shape experiences of abuse, stigma, and discrimination. For example, a trans survivor who is also gay or bisexual may face compounded risks, such as homophobia layered with transphobia, or exclusion from services that only recognise one aspect of their identity.

| Immigration Status and No Recourse to Public Funds | Immigration status is secure, and there is full access to public funds and statutory services. This stability supports autonomy, safety planning, and the ability to access healthcare, housing, and welfare without fear of jeopardising legal status. | Immigration status is temporary, uncertain, or dependent on a partner, creating vulnerability. Restrictions on public funds may limit access to welfare or housing. Documentation may be withheld or threatened, while fear of deportation or negative immigration outcomes may discourage engagement with services. | Immigration status is insecure, with no recourse to public funds and high levels of dependency on external control. Access to statutory support is blocked or severely limited, leaving survivors with little or no means to secure safety independently. Threats of deportation, withdrawal of visas, loss of children, or reporting to immigration authorities may be systematically used to maintain control. These conditions create profound barriers to protection, safety planning, and recovery, requiring urgent specialist immigration-informed advocacy. | | |

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Note:

Survivors with insecure status or subject to No Recourse to Public Funds (NRPF) experience heightened vulnerability as a result of exclusion from welfare, housing, and statutory services, potentially leaving survivors entirely dependent on abusive dynamics for survival, reducing space for action and hindering capacity for successful help-seeking.

Previously the Destitution Domestic Violence Concession (DDVC) provided migrant survivors on spousal visas with three months of access to public funds. This enabled access to benefits and housing support, including refuge accommodation, while applying for Domestic Violence Indefinite Leave to Remain (DVILR) as a long-term route to safety.

In 2024, the scheme was expanded and renamed the Migrant Victims of Domestic Abuse Concession (MVDAC). This broadened eligibility to include partners of people on student and temporary work visas, granting them three months of support. However, unlike those on spousal visas, this group cannot apply for DVILR. Once the concession ends, access to public funds ceases, and survivors face renewed risks of destitution, homelessness, and potential immigration enforcement, including deportation or separation from children.

Important reminder:

- Only trained and certified professionals (e.g. OISC-accredited advisers or qualified solicitors) can provide immigration advice.
- Frontline practitioners must not give immigration advice, but should:
  - Recognise when immigration status or NRPF is a barrier to safety.
  - Document threats, withholding of documents, or immigration-related coercion.
  - Refer survivors to accredited immigration specialists and "by-and-for" organisations who can advise on eligibility for DDVC, MVDAC, or DVILR.

Migrant Victims of Domestic Abuse Concession (formerly DDVC)

Interaction with Systems & Experiences of Criminalisation	Interactions with police, courts, healthcare, and statutory systems are generally neutral or supportive. There is no evidence of unfair targeting or criminalisation, and trust	Interactions with systems are mixed, with occasional experiences of discrimination, stereotyping, or unfair treatment. Apprehension about contacting police or services may arise due to	Engagement with systems is marked by persistent negative experiences, including racial profiling, unjust criminalisation, or systemic bias. Survivors may face threats of arrest, child removal, or		

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	in institutions supports help-seeking and protection.	past experiences of being misunderstood, minimised, or threatened with criminalisation. These concerns can discourage survivors from reporting abuse or fully engaging with support.	immigration enforcement when seeking help. These dynamics are often exploited to reinforce control, creating deep mistrust of institutions and severely limiting access to safety, justice, and recovery.		
Understanding of Intersectional Needs by Professionals	Professionals across relevant services demonstrate strong awareness of intersectionality. Support and interventions are tailored, inclusive, and responsive to multiple layers of identity and experience. Survivors feel seen, respected, and appropriately supported.	Professional understanding of intersectionality is inconsistent. Some needs are acknowledged, but others are minimised or overlooked. Support may be generic rather than tailored, leaving gaps in safety planning and reducing effectiveness of interventions. Survivors may experience frustration or partial exclusion.	Intersectional needs are largely unrecognised within professional responses. Services fail to account for overlapping identities and systemic barriers, resulting in inappropriate or unsafe interventions. Lack of cultural competence, anti-racist practice, or trauma-informed care compounds harm, increasing risk and undermining trust in services.		
Tech Use & Isolation for Migrant Survivors	Technology is fully accessible and used safely for communication, support, and information. Connections with family, community, and services, both locally and abroad, are maintained without	Technology use is occasionally restricted or monitored. This may include sporadic checks of messages, limited access to devices, or restrictions on contact with family overseas. While some	Technology is heavily controlled or denied, resulting in significant isolation. Constant monitoring, blocking of contact with family abroad, or threats linked to immigration status are		

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	restriction, supporting resilience and belonging.	social support remains, these controls reduce autonomy and make communication less reliable.	used to restrict communication. Access to online support, information, or safety planning tools is obstructed, leaving migrant women cut off from vital lifelines and vulnerable to heightened control and dependency.		

Note:

Migrant survivors often rely heavily on technology to maintain contact with family and support networks abroad, access community and cultural connections, and seek information or services. Technology can therefore be both a lifeline and a site of risk.

- Restrictions on devices, online accounts, or international calls can create profound isolation.
- Digital exclusion (e.g. lack of WiFi, language barriers in apps, low digital literacy, or fear of surveillance) compounds vulnerability.
- Immigration status may also be exploited, with threats that online activity will be monitored by authorities or lead to deportation.

Practitioners should explore the role of technology in survivors' lives, recognising that it may provide essential connection and safety planning opportunities, but also identifying where it has become a tool of control.

Language Proficiency	Fluent in the dominant language, with no significant barriers to communication. Services, support, and community engagement are accessible without restriction, reducing isolation and enabling autonomy.	Limited fluency creates some communication barriers. These may include occasional difficulties in navigating services, reliance on informal interpreters, or misunderstandings in professional settings. Language differences may	Minimal proficiency in the dominant language results in significant isolation and exclusion. Communication barriers prevent safe access to healthcare, welfare, legal systems, or community support. Exploitation may include refusal to provide		

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		be used to belittle, exclude, or restrict access to support, contributing to hesitancy in disclosure or help-seeking.	interpretation, deliberate misrepresentation, or using complex language to confuse or control. These conditions reinforce dependency and severely undermine safety planning.		
Note: Family members, friends, or children must never act as interpreters, as this can silence disclosure, create further risk, or reinforce control. Even professional interpreters can sometimes reinforce harm (e.g. through cultural bias, breaches of confidentiality, or minimising survivor experiences). Practitioners must remain alert and ensure that interpreting services are safe, independent, trauma-informed, and culturally competent.					
Impact of Cultural & Societal Stereotypes	Cultural and societal stereotypes do not significantly affect daily life or access to support. Identity is affirmed, and interactions with services and community are free from prejudicial assumptions. Safety planning and advocacy are not disrupted by stereotype-driven bias.	Stereotypes occasionally influence how a survivor is perceived or treated. This may include being dismissed, misjudged, or burdened with expectations rooted in cultural or racialised tropes. Such biases can undermine confidence, complicate engagement with services, or weaken support networks.	Harmful stereotypes are pervasive and systematically shape experiences of abuse and responses from services. Examples include controlling images such as the "strong Black woman," the "submissive Asian woman," or the "hypersexual Black man," which are used to silence, discredit, or deny access to protection. These dynamics reinforce isolation, increase vulnerability, and		

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			significantly obstruct safety, justice, and recovery.		
Female Genital Mutiliation/Cutting FGM/C	No indication of risk related to FGM/C. Awareness of the health risks and legal consequences is strong within the community, and there are no pressures or expectations around the practice. Survivors are supported by services that actively safeguard against FGM/C.	Occasional references, discussions, or indirect pressures around FGM/C are present. Concerns may arise from family or community members upholding the practice under the guise of tradition, modesty, or cultural expectations. Risk may increase where travel to countries with higher prevalence of FGM/C is planned. These dynamics can create anxiety and undermine safety.	Clear evidence or significant threat of FGM/C exists. This may include imminent plans for the procedure, strong family or community pressure, or disclosure of prior FGM/C with intent for continuation across generations. Health consequences may be minimised or ignored, and services may miss or overlook signs due to stigma, cultural sensitivity, or lack of training. These conditions require immediate safeguarding intervention.		

Note:

Mandatory Reporting Duty for FGM:

Professionals such as healthcare workers, teachers, and social workers are under a mandatory reporting duty if they discover that FGM/C has been carried out on a girl under the age of 18. The duty requires these professionals to report such cases to the police. This aims to protect girls and young women, provide support to victims and survivors, and hold perpetrators accountable. It's crucial for professionals to be aware of their legal obligations regarding FGM/C, including how to identify potential risks and how to report concerns appropriately to safeguard those at risk.

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So-Called 'Honour'-Based Abuse	No indication of threats or harm linked to "honour." Survivors live without fear of community or family retribution tied to cultural or social expectations. Safety is not compromised by notions of family reputation or community standing.	References to "honour" or reputation occasionally emerge as sources of tension or control. Survivors may face threats of shame, gossip, or ostracisation for behaviour considered unacceptable by family or community. Fear of reputational damage can discourage disclosure, reduce autonomy, or complicate safety planning.	Abuse is frequently and systematically justified or enforced through notions of "honour." This may include direct threats, physical violence, forced marriage, restrictions on autonomy, or social ostracisation. Survivors face intense pressure to conform to rigid cultural or familial expectations, with serious risks to safety, wellbeing, and freedom. These conditions require urgent safeguarding and specialist intervention.		

Note:

There is currently no statutory definition of HBA in UK law. Creating risks in how agencies recognise, record, and respond to cases, leading to inconsistent safeguarding and justice outcomes. Practitioners must be aware of this gap and apply a safeguarding-first approach even where definitions are unclear.

Some definitions offered for So-called 'Honour'-Based Abuse (HBA): a collection of practices used to control behaviour within families to protect perceived cultural and religious beliefs, and/or honour. This type of abuse can occur when perpetrators believe that a relative has shamed the family and/or community by breaking their 'honour code'.

This 'honour code' can be breached by various means including: becoming too 'westernised', resisting arranged marriages, being in a relationship that is disapproved by the family, or living a lifestyle that does not adhere to traditional cultural norms.

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Unlike many other forms of abuse, HBA often involves multiple perpetrators, including extended family members and sometimes wider community networks, creating a collective dimension increasing complexity and risk, requiring coordinated, multi-agency responses.

It's important to recognise that the term 'honour'-based abuse is a misnomer, as there is no honour in the practice of such violence and control. Many survivors and advocates reject the term because it implies legitimacy or cultural acceptance. Practitioners should use survivor-preferred language wherever possible while still recognising how the term is used in statutory and policy contexts.