

“What to you is domestic abuse?”

“Abuse is abuse isn’t it, physical is worse than mental but if you are mentally upset life is hell, so life is hell”

(Victim of Domestic Violence, Kent)

“Do you feel there is “shame/dishonour” attached to getting support for domestic abuse in Asian community?”

“Yes, problems should be kept in the family and to involve outsiders is considered shameful”

(Community member, Kent)

Oppressed Voices

Understanding the effects of Domestic Violence for
South Asian Women
Rethink Sahayak Community Engagement Project 2006

Authors: Reena Sooch, Gurpreet Kalyan & Jasinder Rai

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Care Services Improvement Partnership 



rethink



The following individuals were part of the project:

Reena Sooch

20 Years old Reena is an undergraduate Psychology student at University of Kent, Canterbury. Reena is a volunteer for Rethink-Sahayak as a 'Befriender' and call handler on Asian mental health helpline. This project allowed Reena to use skills obtained in the classroom into the outside world and the focus being on South Asian women meant understanding her community better and creating awareness about the effects of Domestic Violence. The experience has helped Reena confirm her desire to work in the mental health field and has allowed her to meet numerous influential people and build her presentation and public relation skills. Reena has passionately made the report an integral part of her life for the last 9 months and will now focus on promoting the findings and recommendations to make sure the work by the team will not go unnoticed.

Gurpreet Kalyan

21 years old. Gurpreet is currently a third year student at City University of London; studying for Psychology BSc degree. This project appealed to Gurpreet as it gave her the opportunity to implement the skills learned at university, putting theory into practice. She was employed on this project as a researcher. Duration of this project has developed many skills, including social, organisational and presentation abilities as well increasing confidence levels. She has been involved in developing questionnaire, networking with local organisations, analysing results, writing up the report and presenting findings to public, as well as attending meetings regarding the project.

Jasminder Rai

37 years old. Jasminder is a learning support assistant and student of reflexology. She was recruited for this project as a researcher. This project has given her the opportunity to improve her skills, including computer skills, group work, public speaking and social skills. She is also a volunteer for Rethink Sahayak and is involved in befriending and helpline services and has over 10 years experience in the social work field. Jasminder was involved in the construction of the questionnaire and her primary role was in fieldwork.

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A special thanks to Carol Gosal and Kultar Nayyar who provided valuable and endless amounts of support, their dedication gave us the enthusiasm to persist through the 9 months of project work. To Poppy Jaman and NIMHE for funding this project and giving us the opportunity to be part of a project that is not only influential to public health care, but has provided us with a platform to develop our own skills and test our abilities. To Alia Syed and UCLAN, who provided us with qualifications and training. To Imran Mirza, our support worker, whose feedback, advice and support was valued. Thank you to all those on the steering committee, for keeping the project going, input, feedback and ideas were extremely useful. Thank you Danielle Baillie and Vanessa Pinfold for suggestions for the final report and helping it get to the standard it is. We are grateful to all the organizations who gave us their time. Finally and perhaps most importantly, thank you to all those that took part the study, without your participation there would be no report.

FOREWORD

What makes this report stand apart from several other publications about Domestic Violence that already have been done in BME communities? It is the two words 'Community engagement' which aptly describe what this research has been throughout its nine months. 'Community' is the key to this whole report; community members have done it. We recognised many of the issues our research participants spoke about and felt we could relate to them, given our backgrounds and our own histories and personal experiences. Being from Gravesend, where most of the participants came from, there was a common frame of reference where sentences didn't need to be completed or explained, there was understanding between us and the community which is why this report stands today as a very real and in-depth piece of research. Being from a tight knit group in a small town means everyone tends to know each other and we understand the pressures and difficulties individuals go through growing up in such a culture.

The second word 'Engagement' also sets this report apart from the rest since we truly 'engaged' with the community. We committed to the community in listening and understanding them and most importantly in putting their 'oppressed voices' in this report. There was cynicism and distrust to begin with since many members of community, particularly the older members, who felt

'nothing will change [within services]'

However what they saw in us to allow us into their private lives was true concern and passion, having never done anything like this before and not knowing technical terms within the field it was a conversation they were having, not an interview.

Although we had anticipated many of the outcomes and issues that we saw through the course of our research, we were still struck by the depth of suffering many people had experienced, and the whole process of the Community Engagement project was very educational.

It has allowed us to grow, learn and build skills that we can develop in the future. Most importantly it has allowed personal growth, allowed us all to link with members of our community and get to know them a lot better. It has increased our understanding of our own community and what goes on, for many people the answer to the question "**Do you feel there is shame/dishonour attached to getting help?**" similar sentiments were shared. Many felt...

'Yes, I believe this is because Asian community believe it brings shame to the family and the family name, causing dishonour in community'

'Yes, problems should be kept in the family and to involve outsiders is considered shameful'

'Yes, because most of the victims of this abuse have been brought up with traditional old-fashioned values, therefore feel that they have to put up with this abuse and should not complain or seek outside help.'

(South Asian Community members, Kent)

The key to our research is for the community to be heard, the majority of research participants had never before spoken about the issues in their home with an 'outsider', reasons for this ranged from cultural barriers to never being asked before. The interview with an individual who has suffered domestic abuse stated;

"Nobody had a clue what I was going through I never opened up to anybody. Even you're the first person today".

That interview was the first time that individual spoke about their issues and the reason why they did have the courage to speak, was because of the faith they had in us, the researchers, that this report could bring forward a difference in our community. A sentiment that we hope will be fulfilled.

These nine months have allowed immense personal growth for me personally, and wider understanding of Domestic Violence and its effects. The foundation of research is to find answers to questions and that is where our recommendations have stemmed from since they answer what the North West community need from their services. We hope this research is a step towards bridging the gaps currently present.

**Foreword by
Reena Sooch**

Oppressed Voices Executive Summary

Background

- Community engagement is part of the 'Delivering race equality' action plan set by the Government in 2000 to reduce discrimination within mental health services
- NIHME (National institute of mental health in England) and UCLAN (University of central Lancashire) combined to create a community engagement model that would have the unique mix of Black, minority and ethnic community members stepping into the area they know and doing important research on a specific focus.
- NIHME funded and agreed the nine month pilot project and UCLAN provided training for researchers in mental health awareness and research methods along with a support worker who worked with the team throughout the nine months.
- Rethink – Sahayak is a South Asian, BME specific service based in Gravesend High Street. Rethink, a national mental health charity with over 375 services, and Sahayak, which translates to mean helpful, is a service which has been established for over 10 years with services such as befriending, Asian mental health helpline and BME carers support service.
- Rethink – Sahayak who deal with several various cases throughout the year found they had many Domestic Violence's cases all with similar causation factors and the were certain BME specific issues that these women faced such as uncertain immigration status and cultural barriers which were exclusive to this sector of women.

Our Expectations

- We hypothesise that domestic violence will be prevalent within the North West Kent Asian community.
- We did expect to see a self-reported link between mental health and domestic violence.
- We hypothesised that immigration would be a key factor in domestic violence cases and can prevent South Asian immigrants from accessing aid.

- We do anticipated that cultural issues would play a key role in preventing women in seeking help, the idea of 'izzat' (honour) will, we anticipate, come forward as a barrier and reason why women stay in abusive relationships.

Throughout the course of this project we have understood domestic violence in line with the Government's definition of domestic violence, which is:

'An incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial, or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'

To give background to NorthWest Kent, the area we researched, Kent police provided us with facts such as that out of the 4345 crimes that took place, 900 were domestic in nature therefore **20.7%** of violence in Northwest Kent was domestic. When we refer to South Asian women we are referring to those women from the South of Asian, India, Pakistan, Sri Lanka and Bangladesh. Demographically the most common ethnicity by religion within NorthWest Kent was Sikhs with 6.7% (Gravesend) compared to South East statistics of 0.5%, illustrating how large the BME South Asian community is within this region.

Method

- Questionnaires were our main tool of data collection; we sent 110 out to community and received 60 in return. Questionnaires were targeted to places where we believed women who had experienced domestic violence might be found. Our sample is thus not representative. 2 semi-structured interviews took place, one interview with a service provider and another with a domestic abuse sufferer. A focus group with elderly members of the community was also conducted.
- One of the key limitations of our study is that it is difficult to reach severe sufferers of Domestic Violence since they do not communicate to services and may not feel ready to come forward. We could only approach the population of the community who had links with services or were working women and also those who had access to the English language; questionnaires were kept simple but were in English so many could not fill out without assistance and therefore declined.

Findings

- 55%, which is just over half our 60 participants have suffered a form of domestic abuse.
- Approximately 40% had not experienced domestic violence and a small minority of 5% was 'unsure' of whether they had.

- A large majority of people stated if in a situation of domestic abuse (73%) agreed they would feel shame (*Sharam*), which would prevent them from accessing support. But 20% did not feel this was the case and the remaining were unsure.
- Since the concept of '*izzat*' (honour) is an abstract thought we wanted to understand individual definitions, we therefore gave the opportunity to elaborate on the concept of "*Sharam*". We found a strikingly similarity in the responses from participants who agreed '*izzat*, can be a big deterrent in accessing services.
- The idea of seeking help for a Domestic Violence situation is seen as having a stigma attached to it.
- When Domestic Violence sufferers that participated in this study were asked what health effects they had experienced, the responses revealed that depression and emotional pain were the most common experiences as a result of Domestic Violence.
- Difficulties in sleeping, concentration, and anxiety, mood swings were also common features. These seem to show that there is a definite impact on the mental health of the individual suffering and also that participants had an understanding of what their mental state was like, under distress.
- The most common result of a Domestic Violence situation seemed to affect feelings (mental well-being), mostly of being worried and anxious, but also depression, loss of self-confidence and being scared and fearful.
- Of those that suffered, a considerable proportion of people did consult their GP.
- Anti-depressants were the main options for support given, followed by counseling.
- 38% of participants would talk to a member of their family or seek advice from a friend before approaching any service.
- Ambiguous immigration status can prevent individuals seeking help and can also be a factor that creates a domestic violence situation since knowing the Woman is not a permanent UK resident, the families can have a sense of power over the girl and create a domestic situation.
- Over half of our participants agreed that deportation fear is a large issue for non-UK residents. 27% were unsure of this statement.
- Uncertain immigration can not only act as a tool for Domestic Violence, allowing perpetrators to use it as a threat, but legislation also makes it difficult

for suffers in this position to attain help due to policies that can prevent them accessing aid.

- Women with uncertain immigration status at a disadvantage because they often have language barriers, but their lack of knowledge in services and legislation make them more reluctant in reaching out and accessing help.
- 83%, agreed there is a language problem in accessing aid, this links with the lack of understanding of BME specific services where bi-lingual workers would be available. Language can be seen as a major barrier in an immigration problem; alongside needing to access a service since communication is vital,

Recommendations

- We recommend funding for a trained and accredited appropriate language counsellor for South Asians on a trial basis within Rethink – Sahayak, which is one of the few recognised BME organizations within NorthWest Kent.
- More promotion and education on Domestic Violence in a format of an Asian Women's day.
- A clearer perception of the issues surrounding immigration law and what implications there are for individuals in such a situation needs to be highlighted in an accessible format such as a leaflet.
- A centralised information/education resource such as a diversity toolkit should be available to Service Providers and frontline practioners such as GP's.
- Peer support and Peer (general) advocacy services
- Social events such as plays, films or magazines for British South Asian youth to educate and prevent future generation from being part of Domestic Violence.

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Disclaimer:

The views expressed in this report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at University of central Lancashire.

Section One: Introduction

1.1 Community Engagement programme – Background Research

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the mental health needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about mental health issues, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the six month process to learn about mental health related issues. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community

who would have gained from undertaking this work. They would have learned about mental health issues, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Mental health Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Drugs and Rehabilitation
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aimhigher.

1.2 The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate)

that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organization. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host

or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

organization and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project³. The steering group is an essential element of the project: without one, it is difficult to see who the community is engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

1.3 The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

1.4 Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

1.5 Delivering Race Equality

The Delivering Race Equality in Mental Health Care (DRE) is an action plan to improve mental health services to all sections of the BME communities. There is a need for a focus to be given to recognising the importance of the diverse needs of both Black women and Black Muslim Women which is the focus of this research project.

In 2000, the NHS plan (Department of Health 2000) recognised the need to support women in maintaining their mental health. Discrimination based on gender, race, culture, religion, ethnicity and age faced by women from BME communities can have an impact on their mental health;

Women from BME communities are more likely to live in deprived areas , experience racism and have difficulties in accessing appropriate mental health care; Women are more likely to occupy both the poorest and most deprived positions across all cultures which will impact on their health as deprivation is one of the most consistent predictors of a mental ill-health burden.

Ref. Stewart D,E. Rondon M.. , Damiani G., Hanikman J. (2001) International psychosocial and systemic issues in women's mental health. Archives of Women's Health 4; 13-17 as quoted in 'Supporting Women Into the Mainstream" (Spring 2006)

The implementation guidance report produced by the Department of Health in September 2003 'Mainstreaming Gender and Women's Mental Health' is built on by the best practise guidance document 'Supporting Women into the Mainstream' Department of Health Spring 2006. Supporting Women into the mainstream provides a framework to support commissioners – primary care trusts, local implementation teams and local authorities – in developing women only community day services.

Delivering Race Equality in Mental Health Care (DRE) is an action plan for achieving equality and tackling discrimination in mental health services in England for all

people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants.

It draws on three key recent publications in particular:

- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England;
- Delivering Race Equality: A Framework for Action; and
- the independent inquiry into the death of David Bennett (although DRE itself is not a direct response to the inquiry's report).

David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff. As well as DRE, this document contains the Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death. The responses are overwhelmingly positive and, taken together with the action plan in DRE, comprise a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users.

The programme is based on three 'building blocks', first proposed in the consultation version of DRE:

- more appropriate and responsive services - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children;
- community engagement - delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and
- better information - from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

The vision for DRE is that by 2010 there will be a service characterised by:

- less fear of mental health services among BME communities and service users;
- increased satisfaction with services;

1.6 Rethink Sahayak

Rethink is a national mental charity that provides services and campaigns on behalf of those affected by mental illness. Rethink's Mission statement

"Rethink exists to improve the lives of everyone affected by schizophrenia and other severe mental illnesses, by providing quality support and information and by influencing local, regional and national policies".

Sahayak, which is a Hindi word, translates to mean 'helpful'. The project was set up in response to the growing need for support for individuals within the minority ethnic communities experiencing mental health problems from the Dartford and Gravesham area. The scheme offers a free, independent and confidential Information & Support service to people living in Asian communities, whether to those within the family setting or who live on their own.

Trained volunteers work to provide this support as well as promote and protect the rights and interest of the client. Referrals are received from statutory, voluntary and independent sectors as well as from carers, families, and those who choose to self-refer. The service is also aided by an advisory committee, which consist of local professionals and lay people.

Services that Sahayak offer are Asian mental health helpline and a BME carers support group.

1.7 Background to community

All figures taken from Office of National statistics (ONS).

Mid – 2003 last population estimates were carried out. Resident population ethnicity and religion breakdown from 2001 – *we anticipate increase in figures with population growing over last few years.*

South East region 8,000,615 was the last population estimate.

Last population estimate for Gravesend: 95,200 and Dartford: 86,200.

The ages between 16 and 44 are significantly the highest in both Gravesend and Dartford. The gender split of the residential population for both towns was 49% male and 51% female and the average age of each town was also close; Gravesend was 38.7 years and Dartford 37.5 years.

The ethnicity breakdown is shown in table one below and also describes a comparison with the national averages for South East and England and Wales.

Table one: Percentage of resident South Asian population in 2001

Ethnicity	Gravesend (%)	Dartford (%)	South East (%)	England and Wales (%)
Asian: British	8.23	2.7	2.3	4.4
Asian: Indian	7.19	1.9	1.1	2.0
Asian: Pakistani	0.29	0.1	0.7	1.4
Asian: Bangladeshi	0.23	0.1	0.2	0.5
Asian: Other	0.51	0.6	0.3	0.5

The table illustrates clearly that both Gravesend and Dartford have a large South Asian population, especially Gravesend where the maximum number of participants were accessed. To gain a better understanding of the residential population in North West Kent we also wanted to understand what religion each ethnicity belongs to. In **Gravesend** (by percentage) the Hindu's comprised of 0.6%, Muslim (0.8%) and Sikh (6.7%) compared to **Dartford's** religion breakdown where, Hindu (0.8%), Muslim (0.7%) and Sikh (1.1%). This is compared to the **South East** where, Hindu (0.6%), Muslim (1.4%) and Sikh population was 0.5%. This highlights how the Sikh community is considerably large in both Gravesend and Dartford.

North West KENT Police statistics on Domestic Violence

4345 violent offences between November 2004 – October 2005 and that tallied 15% of the total crime in North West. Out of the 4345 crimes, 900 were domestic in nature therefore **20.7%** of violence in Northwest Kent was domestic. 79% of victims were female and 30-39 was the age range recorded as the highest in risk (33%) followed by 20-29 (27%) and 40-49 (20%). Broken down in 'self-defined' ethnicity the figures showed 6.8% of Domestic Violence cases were South Asian and in numbers, 133 Indian, 16 Pakistani and 1 Bangladeshi.

1.8 Background research

Throughout the course of this project we have understood domestic violence in line with the Government's definition of domestic violence, which is:

'An incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial, or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'

The majority of perpetrators are male and between 80-90% of victims are female (Women's aid, 2004). Domestic violence cuts across race, sexuality, gender and class and domestic violence accounts for 17% of all violent crime across England

and Wales. The Home office has acknowledged that domestic violence can include culturally specific forms of harm and our research hopes to highlight what effects domestic violence can have on the South Asian community.

One in four women experience domestic violence in their lifetime (Women's aid, 2004), this is a factual figure based on reported cases. However domestic violence, also known as 'interpersonal violence', is an act that is often concealed from authorities and community despite an average of two women being killed in Britain per week by their partner (Joni Seager, 2003). In 1983 a study by Hopayian exposed that 89 per cent of women in refuges had consulted their general practitioner (GP) but nearly half hid the fact that they were being abused. Research from Mullender (1996) brought forward that only two to 27 per cent of incidents were reported to the police, such an alarmingly low figure and furthermore only physical and/or sexual abuse is recorded, emotional and psychological abuse is ignored in statistics.

Theoretical explanations for domestic abuse have provided explanatory frameworks such as the 'family violence perspective'. The 'family violence' approach (Kurz, 1989) viewed marital violence shaped from the personal characteristics of the wife or husband or from the stress factors, internal or external, that affect the family. Character flaws are seen as the basis of violence in a family unit, family theorists state the causal factors to arise from violent socialization during childhood or learned violent behavior or lack of self control (Stacey and Shupe, 1983). External stress factors do fuel violent behavior since frustration can stem from lack of goal fulfillment, low income, unemployment and cultural deprivation (Freeman, 1984). The underlining viewpoint many family theorists adhere to is that violence is a learned and cyclical behavior.

The dominance of men globally in the social structure of society is the root of the 'feminist' viewpoint. The wife being the victim is a reflection of the social structure (Pagelow, 1984), Wife abuse is not an act of deviance or breakdown but has risen out of the same normative structure that defines women as inferior. The social structure insolently reaffirms dominance and aggression as positive attributes in men and women are under represented in all spheres of social, economical and political life (Dobash and Dobash, 1981).

Focusing on a Black and Minority Ethnic (BME) group such as South Asians the facts and figures on domestic violence are unrepresentative as past research into Domestic violence found no distinct differences for BME communities (British Crime survey, 2003) and did not take into account factors such as cultural barriers or immigration issues. The Asian women referred to here are those whose families formerly came from South Asia – that is, India, Pakistan, Bangladesh, Sri Lanka and Nepal. However, South Asians in Britain come from a broad range of communities with different religions, languages, cultures and beliefs. Additionally within each community, people will vary as to their social, financial and educational background and their aims and attitudes. Domestic violence is a taboo subject and in a conservative society such as the South Asian community it is unspoken about and incidents are rarely recorded primarily since marital violence has been considered a

part of the normative structure in patriarchal society. The abuse that is being suffered is not the sole issue, language barriers, immigration status and cultural expectations all affect the victim. An Asian woman's respectability, honour and status tend to be dependent on her marital status; therefore grave consequences deter a woman from seeking help. A Government study in Punjab (2001) found in Pakistan 42% women accepted violence as part of their fate, 33% felt too helpless to take any action, 19% protested and 4% took action against it (Seager, 2003).

Violence can be a learned behaviour, the Gender stereotyping in South Asian community of the man being most powerful and the woman being expected to be a docile homemaker who keeps the family together, are a huge part of the pressure for domestic abuse victims. Domestic abuse is seen as a closed door issue if a woman was to speak up she would not gain support but be outcast for 'shaming' the family since 'izzat' (respect) of the family is her responsibility. Izzat is seen through the woman, 'she (a daughter) is the vehicle for the izzat of the whole family, whether the one into which she was born or the one she marries. This izzat is the noose around her neck. It curtails her freedom to study, to work, to do what she wants, because family honour is always at stake. The 'izzat' kills her off, bit by bit'. (Kiranjit Ahluwalia, *Circle of life*, 1997, page 112).

The culture for the Asian community makes it difficult to reach out to people for help, marriage failure will be seen as the woman's fault and no matter what circumstance whether adultery, addiction or domestic abuse a woman will be blamed for the failure of the marriage. This pressure is what causes suppression and weakens a woman to speak about her problems. 'Honour killings' held in rural villages of India, assault, abuse and kill those women who dare to take the step of shaming a family, over 1,000 women were killed in Pakistan in honour killings (Amnesty, 2001).

Trauma of any sort will cause emotional stress and have an effect on your overall health but the most harmed will be your mental health. Kumar (2005) in a population based study found a distinct correlation between domestic abuse and mental health problems, symptoms such as depression, anxiety and loneliness. Poor mental health was also linked with other risk factors such as witnessing or having been the victim of parental violence during childhood, and more general factors such as lower socio-economic status and lack of education.

Alienation is an emotion that suffocates many South Asian women in Britain; many women are denied the freedom to make friendships outside of the family since the perception is that outside influences are generally a bad thing. This plays a key factor in the high rates of suicide and self-harm within the BME community. Research by the National Inquiry into Suicide found a 6% rate of suicide for minority ethnics with mental health problems, and the greatest percentage of that were South Asian people with 34%. Findings also suggest that young, married South Asian women are a high risk group for suicide (Bhugra et al, 1999.).

A survey of hospital admissions for attempted suicide and self harm, many by attempted poisoning, showed that young Asian women rates of admission were three times those of white British women. Other factors to consider were that more

of the South Asian women were married and were less likely to have a diagnosis of previous mental illness. An analysis of suicides among Indian immigrants in England and Wales for 1970-1978 showed a large number of suicides among young women (particularly in the 15-24 age group), who were more likely to be married. Burning was found to be a common method of suicide in this group during that time span. Indian women had significantly higher suicides rates than Indian men. Muslims had relatively lower rates of suicide than Hindus (Raleigh, 1996). Further study of suicide patterns in minority ethnic groups in England and Wales demonstrated that during 1988-1992, 1,979 minority ethnic women between 15-34 years committed suicide. The suicide rate found for Asian women was nearly double their proportion of the population, with an excess mortality rate of 43% (Raleigh, 1996).

One of the more representative studies was conducted by a group called the 'South Asian Women's Organisation' (SAWO). The study took place over three years from 1990. To enable them to have representative evidence and analysis data collection was drawn from diverse sources in the United States of America (USA). Tools used included unstructured tape interviews, questionnaires, participant observation in other South Asian women's organizations and gathering of secondary information such as newspaper articles. During in-depth interviews with 25 abused women certain factors came forward through this study as to the causes and consequences of domestic abuse within immigrant communities, USA. They found gender norms result in South Asian immigrants being largely male led and them having to be dependent. Such women tended to be isolated from friends and family and they had to rely on their husband's economic, social and emotional support and these factors combined forced them to stay in abusive relationships (Abraham, 2000). External barriers are also important since they prevent them from using legal and social resources, immigration law has gone through changes and has improved for immigrants but it is still difficult for dependent immigrants to obtain legal assistance. Language barriers and the unfamiliarity of the legal system and awareness of the prevalence of racism, immigrant women are fearful and hesitant to approach police, evidence for this came from Abraham's (2000) study which highlighted the way the police, counselors, courts and shelters were 'insensitive' to the needs and concerns of abused South Asian immigrant women in the USA.

Taking into account all past research and findings we decided that the key things we will concentrate on in our project were mental health and cultural issues for a south Asian woman in a Domestic Violence situation. We will also try and highlight how big an issue immigration status can pose for North West Kent Asian women.

Immigration control is a huge issue for South Asian women, those who have entered the UK to join their British husband would be subject to a two year probationary period, 'two year rule', this means that these women if trying to seek help out of domestic violence situation are not allowed access to public funds, such as social security benefits or council housing. The women here under the 'two year rule' can apply to remain permanently in the United Kingdom (UK) at the end of the

probationary period, as long as their husbands support their application (Home office guidelines, 2003). If the marriage breaks down before obtaining permanent leave the woman could face deportation. The choice therefore for many women in extreme circumstance is between to stay within an abusive marriage and risk their lives, and that of any children, or leave the marriage and face deportation and potentially destitution

However immigration rules do state that if the woman can show domestic violence during the probationary period, she can stay in the UK permanently. The steps that need to be taken are a civil court injunction, conviction or a police caution and if these steps have not been taken then a medical report, letter from social services or a report from a women's refuge confirming domestic violence will be considered (Home office, 2001)

Cultural issues are another factor we have taken into account, the feelings of 'izzat' and shame that can stop women from accessing services, Abraham (2000) showed this was a big factor in the USA therefore being a similar society we do anticipate similar results.

The other key part of our research will be the consequence on mental health and whether victims of domestic abuse seek any form of help. Neurobiology states that the organs in the mind control everything and therefore when stress affects an individual it starts shutting down your immune system along with developing fatigue, anxiety and loss of self-esteem. Depression can be genetically predisposed but social factors are found to trigger the mental illness and domestic violence being so high in stress can cause an individual to develop a form of depression or even agoraphobia. These are assumptions therefore we will be analysing though our data whether there is a link between mental illness and domestic violence and pose the question that if there is a link, why are people not accessing mental health services?

1.9

Our Expectations

- We hypothesise that domestic violence will be prevalent within the North West Kent Asian community.
- We do expect to see a self-reported link between mental health and domestic violence.
- We hypothesise that immigration is a key factor in domestic violence cases and can prevent South Asian immigrants from accessing aid.
- We do anticipate that cultural issues will play a key role in preventing women in seeking help, the idea of 'izzat' will, we anticipate, come forward as a barrier and reason why women stay in abusive relationships.

Section Two: Method

2.1 Project Focus

In our community engagement project we selected our research focus to be domestic violence, we went further to link issues such mental health and immigration which are thought to be closely related. We wanted to concentrate on the South Asian BME community and selected our sample to be female south Asian women.

We used questionnaires and semi-structured interviews as our data collection method. Questionnaires are our primary source of data since they allowed us to reach the maximum amount of individuals and also allowed us to draw comparisons more easily when analysing our data. We were only doing selective semi structured interviews to help us have meaningful quotes and a better understanding of data found from the questionnaires.

We considered using Focus Groups throughout the project but decided we would only use them if our data needed more evidence, so this was an option we kept open. We also decided to involve service providers in our sample since it's important to have their opinions of current service provision for South Asian women. We used questionnaires and semi-structured interviews to reach service provider stakeholders as well. Our data is both qualitative and quantitative. Qualitative is rich narrative data, generated through conversations to provide in-depth exploration of a topic with an individual or group. Quantitative data allows us to summarise a subject using figures.

2.2 Generating the questionnaire: process

We brainstormed ideas as a group of what information we wanted to gain and this helped to narrow down our focus. Domestic violence was the key idea we were examining but we wanted to link cultural expectations, mental health and immigration issues. We therefore created three sub headings:

- **Personal information** – this is needed for demographics of participants and to get the background of an individual.
- **Awareness** – This was to gain an understanding of what the individual sees as domestic violence and to know whether they have experienced domestic violence of any form. We also linked in any mental health questions to also see if they had an understanding of what mental illness is and whether they themselves had suffered. This was the section which would give us the bulk of the core data we were interested in.
- **Information services** - The final segment was decided to be information services, to gain an insight into what North West Kent South Asian community members knew about the services available, to know whether they would access services in their community and their general opinions on them. This section would enable us to give better recommendations from our report since

we would have an understanding of what the community is looking for from their services.

When generating the questions we kept in mind we need it to be accessible to all people, therefore the language and style must be kept simple. We then wrote our questions in a logical, coherent manner and knew we had to write sensitively when dealing with such a “taboo” issue to ensure it does not offend anyone. We created many drafts before deciding on the final format (see appendix).

Compulsory part of any research is to ensure any ethical issues are controlled, with a questionnaire one must write a consent form (importance of declaration) stating the participants has ‘voluntarily’ decided to participate and can retract their data at any point without reason. We also included a cover sheet explaining the purpose of our project, and also a final debrief was included which gave the researchers details if they wished to get in touch and also free phone helpline numbers were attached since it is a sensitive subject and many may need to talk after reliving or writing about it, (see appendix 5, 6 and 8 for cover sheet, consent form and debrief). Anonymity is important to many, not being linked to their answers gives confidence to participants to be more honest in their answers to questions. In our project no participant provides their name when answering a questionnaire, each questionnaire is marked with a number and that is their identification, no information will be traced back to the individual.

While still in drafting stage we carried out five pilot questionnaires to check face validity (grammar, order, understanding content) to ensure it was simple to understand and easy to use. We made extra amendments after this since we were made aware certain sections needed more clarity. At this stage we were considering having an extra case study questionnaire strictly for ages 16 – 21, this is because being the youngest bracket many may not have experienced Domestic Violence but we still needed their opinions, therefore we were going to have them read a real life scenario (Kiranjit Alhuwalia’s story) and wanted them to give their views. This turned out to be too complex since the case study format wasn’t liked at the pilot stage, also background research and statistics showed that many 16-21 do experience Domestic Violence so they would have an understanding, therefore we stuck to a generic questionnaire for all. (See appendix for main questionnaire). Pilot two was then carried out after all amendments, all members of steering committee and UCLAN community worker and our main link from NIHME also checked the questionnaire to make any final changes. All green lighted the questionnaire and fieldwork began.

2.3 Steering committee

Central to the success of the community engagement project is an active steering committee. The overall aim of the steering committee is to guide and inform the work of the community engagement research team. The steering committee’s aims were to meet regularly for updates during the life of the project and to offer their professional expertise. Where possible and/or appropriate, the steering committee members offered the research team support by sharing information and contacts. The key elements that the steering committee specifically inquired on were ethics,

questionnaire content and drafting of the report. The steering committee was made up of a wide range of stakeholders including health professionals, Rethink staff, voluntary and community sector parties, UCLAN staff, statutory sector agencies such as the police and service users/carers.

2.4 Fieldwork sample

There were two target populations for our project:

- South Asian women
- Mental health service providers

It is important to clarify that the samples in this research are not representative of the North West Kent South Asian Community because we targeted the questionnaires to places where women with experience of domestic violence might visit. We drew links in with services already established in the community, Ravi refuge, Service user's forum, KENT police, Bangladeshi women's group and Rethink – Sahayak. After accessing participants from these areas, we used links through people we met to distribute the questionnaire further, word of mouth became our most powerful tool since the Asian community is so close knit. We were able to gather the bulk of our data through Asian women's specific services or workplaces such as beauticians and day care centres. We did mini presentations wherever we could to raise awareness of the work we were doing, we attended many conferences on Domestic Violence and also local forums. Fieldwork was carried out for two months intensely then in the third month we began to look back and check where our weak areas were. We found that we only had 4% 50+ participants; therefore we felt it necessary to target more of the elderly community members. We therefore linked with a service user's forum which is specifically for South Asian elderly community members and held an informal forum with them. We sent out 110 questionnaires, held two semi-structured interviews, one with a service provider and another with a victim of Domestic Violence. We held one focus group with elderly service users and we began to analyse our data via SPSS database.

2.5 Transcription of semi-structured interviews

Transcripts from our target group were recorded without going in to great detail over pauses and the length of sentences. Although it is necessary to represent as accurately as possible the way in which individuals communicated their experiences and thoughts, we were more interested in the content of what was being said, and linking our thoughts to our quantitative data. We chose an individual from the community who fitted our most common representative category, therefore female, Indian, who is Sikh by religion and between the ages of 40-49.

2.6 Focus group

There was not an intention at the start to have a focus group since time and location would have posed problems, however as we approached mid-way and saw that the data we had collected was missing an integral age group, that of 50+. We made attempts to sit and fill out questionnaires with service users but they were very firm

on not wanting to be part of our research, we therefore drew links with a local service user's forum that tend to have an age span of 45 – 75. The group consented to giving their views on 'domestic violence within the South Asian community', however they did not want to be tape recorded therefore notes were taken while a debate began and we have powerful quotations, thoughts and theories (see appendix) and underlying explanations for what they consider domestic violence to be.

2.7 Location

We knew from the onset we are focusing on North West Kent, and the two main south Asian populated towns are Gravesend and Dartford therefore most our data has been collected from these towns. Links we made to service providers meant that we involved women who met in the area of North West Kent but may have been living nearby.

2.8 Obstacles

Reaching victims of domestic violence is the first and biggest obstacle we face since these people are not in a position to come forward due to their circumstances.

Extraneous variables always limit studies; therefore individuals being highly stressed and lack of time meant service providers were unable to give their time to our question, the questionnaire we presented was too open.

Time was a huge obstacle since nine months only gave us realistically three months to do field work. Lack of understanding of what domestic violence is and how immigration poses questions was another key element

Language barriers were present; all researchers are bi-lingual having linguistic skills in Punjabi, Hindi and understanding Urdu, however we had a participant who was Bengali speaker and had to have an outside translator help fill out the questionnaire.

Section Three: Results

The results section illustrates the findings of the questionnaires and interviews that were implemented for this project. All in all, there were a total of 60 female respondents,. We thus achieved a 55% return rate of questionnaires.

Valid percent – Is the calculation of percentage of participants who responded to question

Cumulative percent – Is the valid percent-added together row by row to calculate to 100%.

3.1 Personal characteristics

We collected data on a range of variables. As targeted all the responses were from women, 28 had been born in the UK (47%) and 32 were born abroad (53%). 47 women had UK citizenship (78%), 7 were refugees (12%), 5 lived on extended leave visas (8%) and one person reported 'no citizenship status' (2%). All the women reported heterosexual (straight) sexuality. Figures 1 to 7 describe the age, ethnicity, religion, marital status, type of marriage and spoken and written languages of the women in our sample. Core characteristics were Punjabi (and Sikh) British women who spoke English and Punjabi and had arranged marriages. Only 6.7% of our sample (4 women) identified they had a disability.

Figure one: Disability

Disability

	Frequency	Percent	Valid Percent	Cumulative Percent
yes	4	6.7	6.7	6.7
no	56	93.3	93.3	100.0
Total	60	100.0	100.0	

Figure Two: Employment

Employment Status

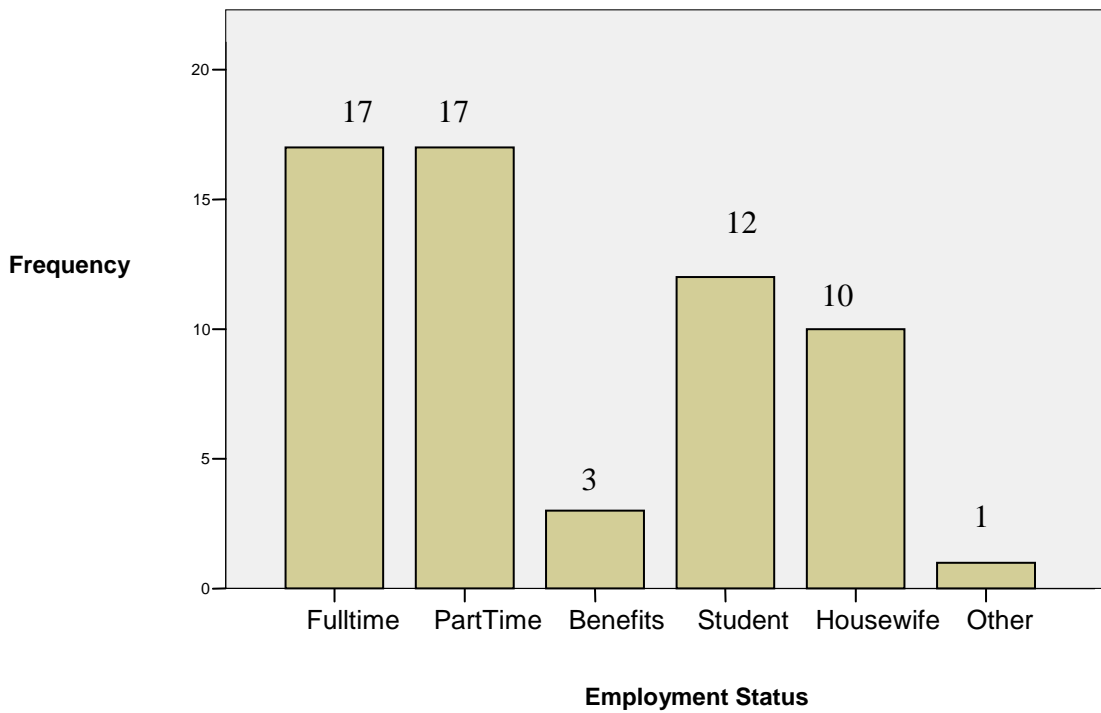


Figure Three : Age of sample (n=60)

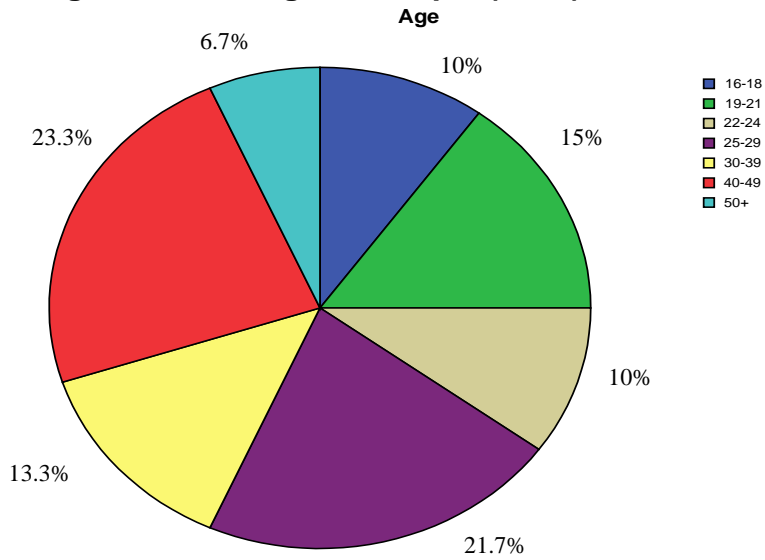


Figure Four: Ethnicity of sample (n=60)

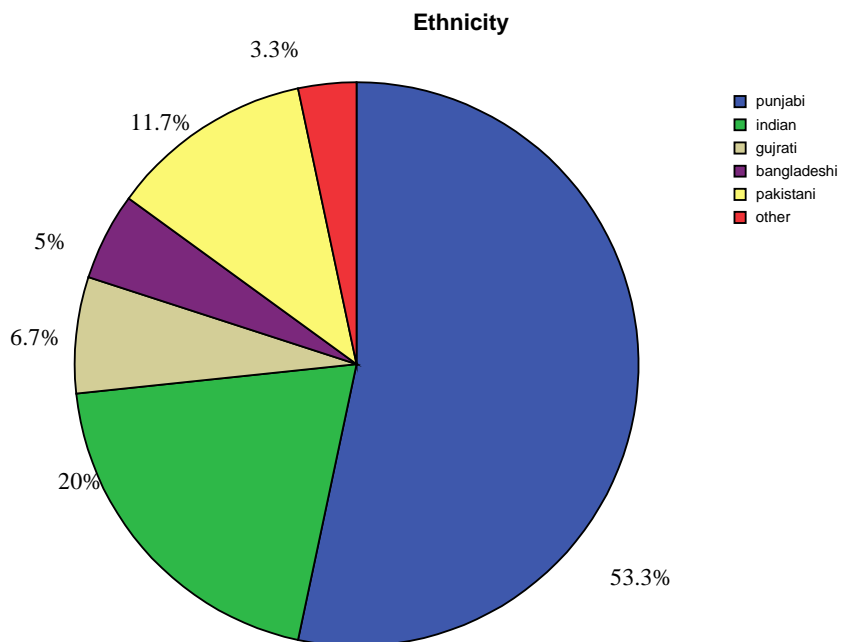


Figure Five: Religion of sample

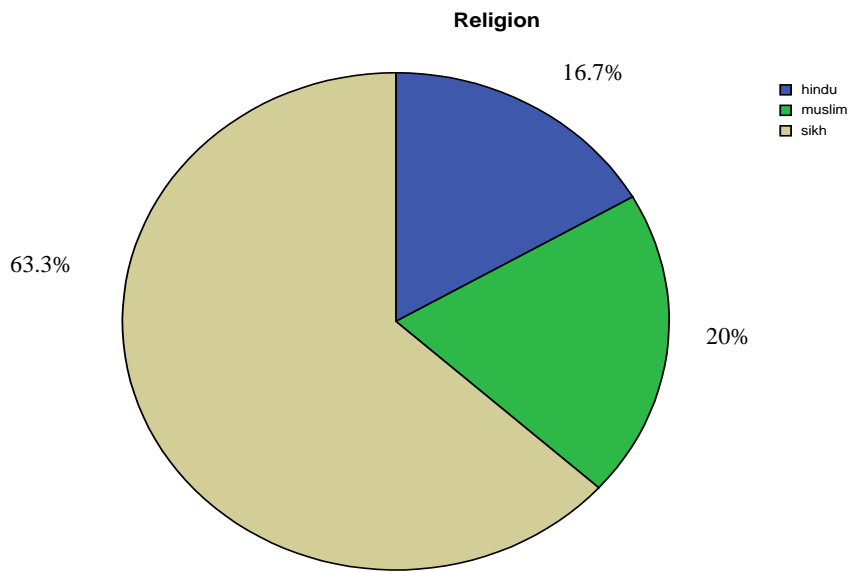


Figure Six: Bar graph to show participants marital status

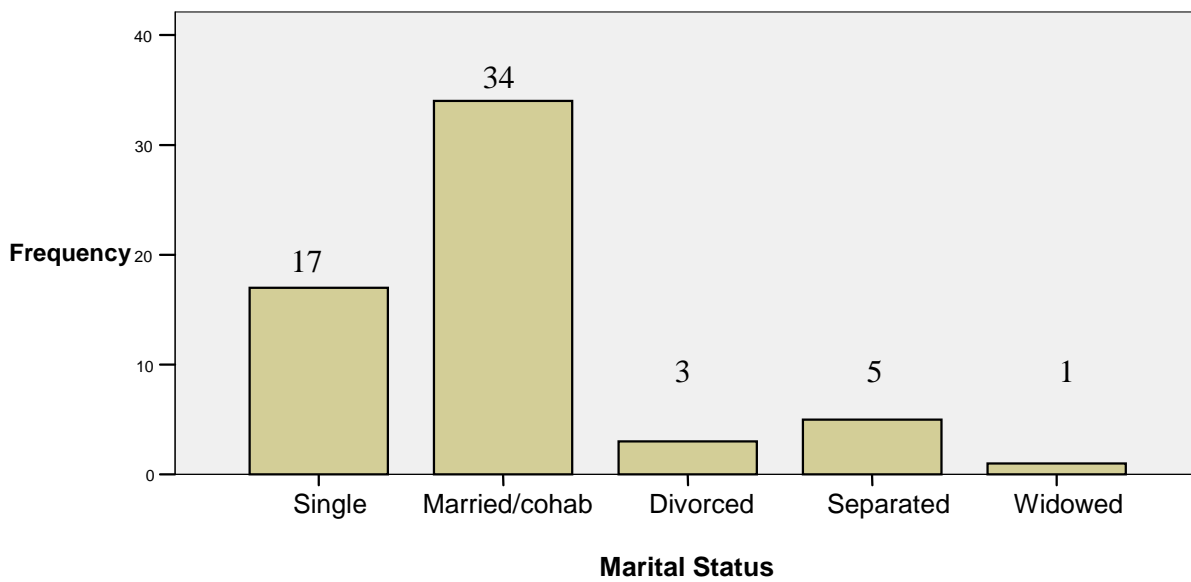


Figure Seven: Bar graph showing participants type of marriage

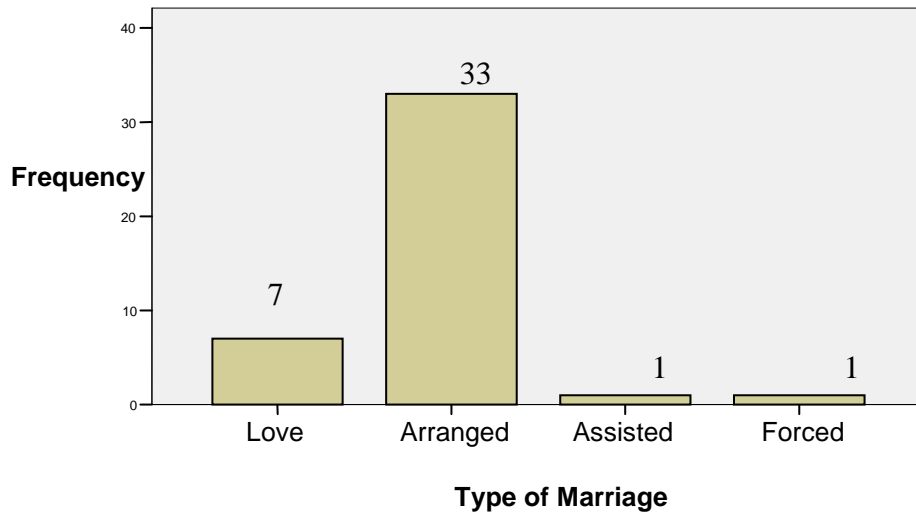


Figure eight:

Figure Nine:

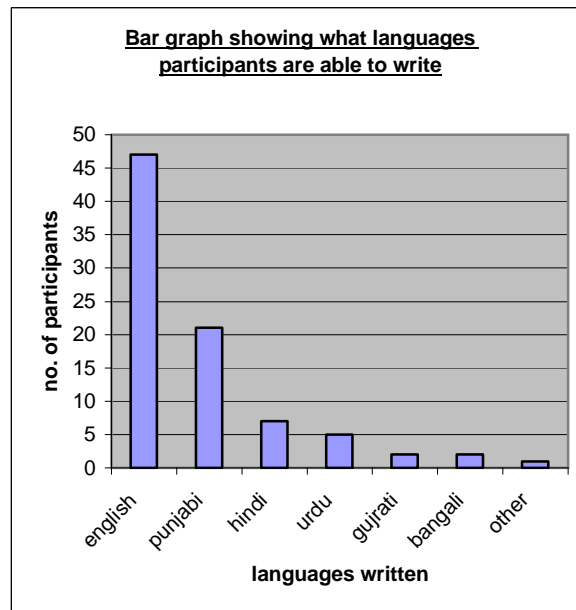
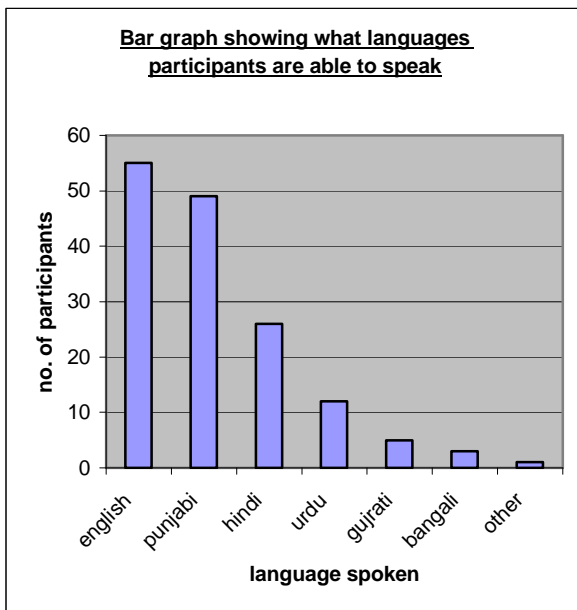
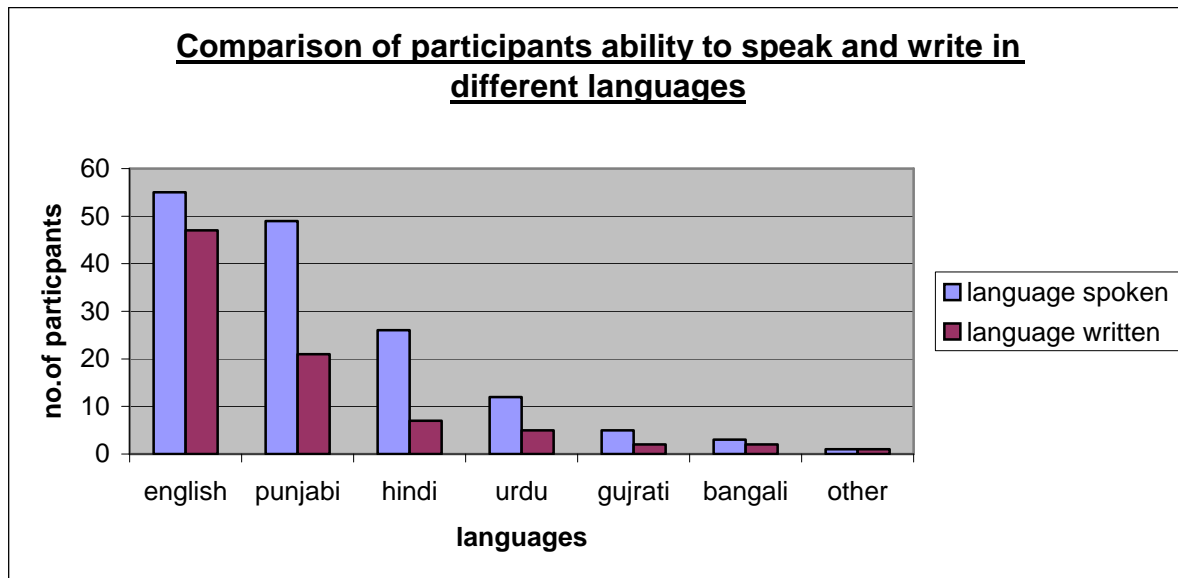


Figure Ten:



3.2 Awareness

The questionnaire asked women whether they believed that domestic abuse existed within the Asian community in the UK. All but one person agreed. Figure 8 describes who women rate domestic violence within the household – the majority agreed or strongly agreed. Figure nine explores this data by country of origin. Agreement was high in both groups – 63% (20 out of 32) for the non-UK born group and 75% (21 out of 28) for the UK born group. Fewer neutral opinions were provided by the UK born group of women.

Figure Eleven: A bar graph to show whether participants agreed with the statement. "Domestic Abuse is a big problem in most Asian Households"

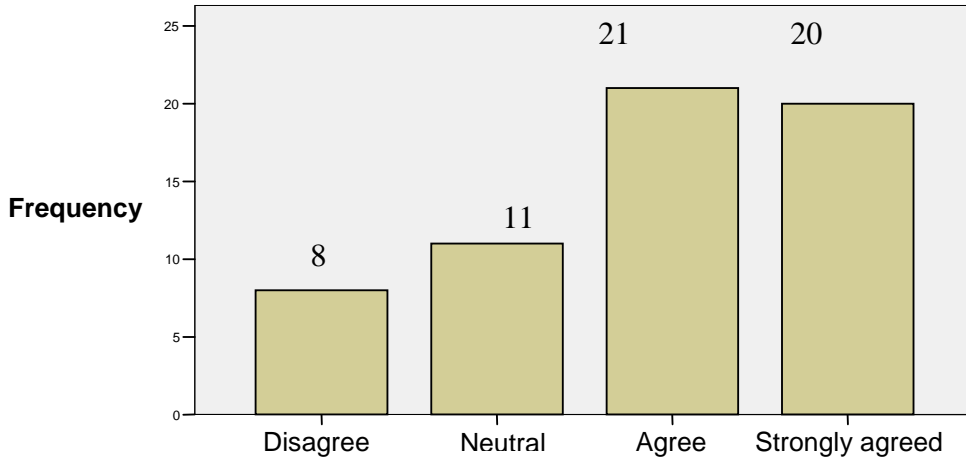
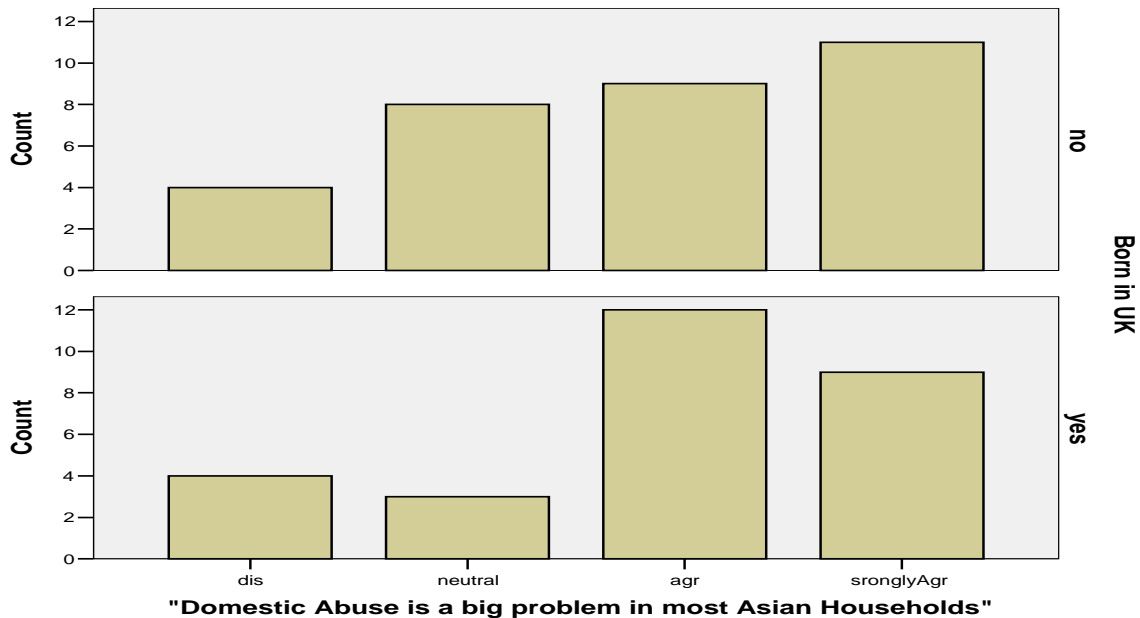
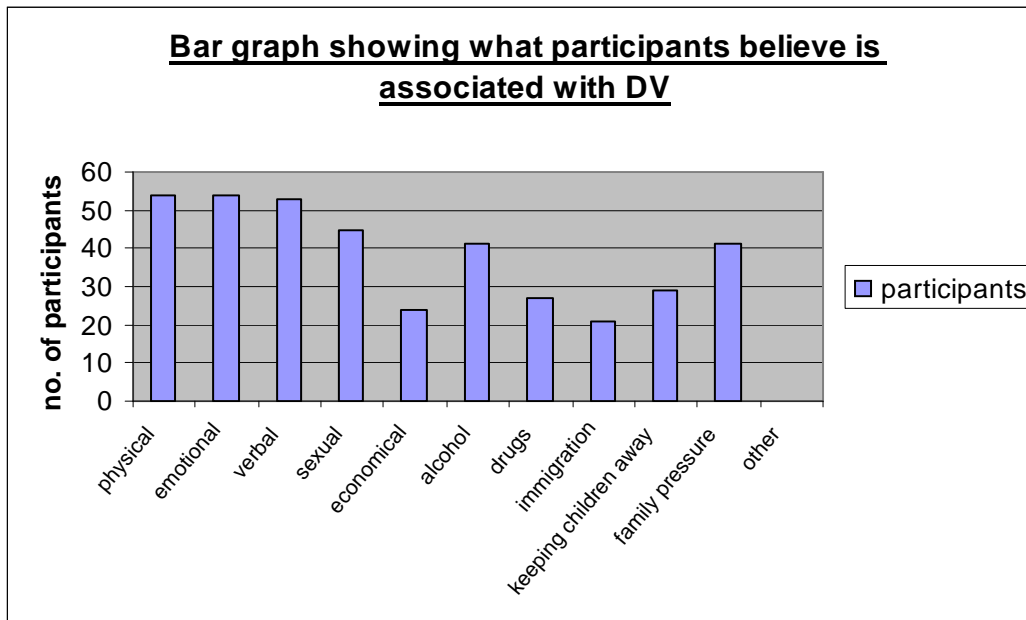


Figure Twelve: Perceived domestic violence in household by country of birth.



Domestic violence is not always associated with a range of factors. The questionnaire asked women to indicate which factors they associated with domestic violence. The majority of women identified physical, emotional and verbal abuse, followed by sexual, family pressure and alcohol (see figure 10). We also asked about perceived shame / dishonor attached to requesting support for DV: 44 women identified shame / dishonor, 12 did not and a further 4 did not know. A section of quotations describing this them are provided below.

Figure Thirteen:



Do you feel there is “shame/dishonour” attached to getting support for domestic abuse in Asian community?

‘Yes, because it’s public humiliation, the Asian community are judgemental’

‘Yes, I believe this is because Asian community believe it brings shame to the family and the family name causing dishonour in community’

‘Yes, it is made to be a woman’s duty to accept everything in a marriage and to believe things will get better as life moves on’

‘Yes, problems should be kept in the family and to involve outsiders is considered shameful’

‘Yes, because most of the victims of this abuse have been brought up with traditional old-fashioned values, therefore feel that they have to put up with this abuse and should not complain or seek outside help.’

‘Yes, I think most Asians think that community will think less of them’

‘Yes, people afraid of losing face in the community’

‘Yes in our society, they believe that this is shameful for family, if any sufferer wanted to take this issue outside the home or to the police. This is because we people are still narrow minded’.

'Yes, Asian households believe in keeping personal matters 'personal'. To face the outside world as if life could not be better!'

'Yes, family will not support you if speak against or about house problems'

'Yes, on the outside Asian families try to convey they have a happy and fruitful loving family life. By getting support is considered to break that 'illusion' and admit problems exist. Thus causing shame in the community'

'Yes, men are taught they are better than women therefore problems occur and women can't speak for sake of saving family disgrace'.

Although domestic violence is a difficult subject to explore, the respondents to the questionnaire did reveal many details about their personal experiences. In our sample of 60 women, 33 women (55%) has experienced DV personally 24 had not and 3 were unsure. Figures 11 to 13 describes the identified abuse experienced by women in the sample.

Figure Fourteen:

Bar graph to show how long participants had experienced Domestic violence

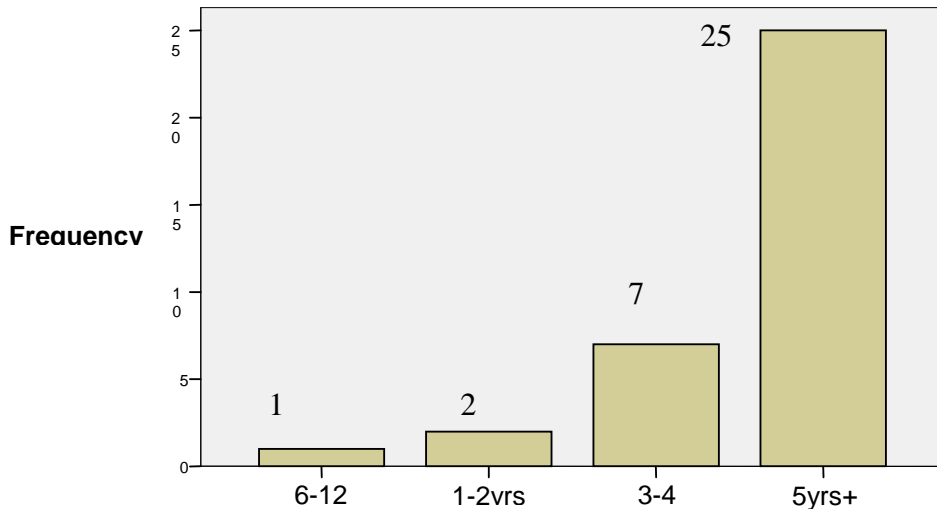


Figure Fifteen:

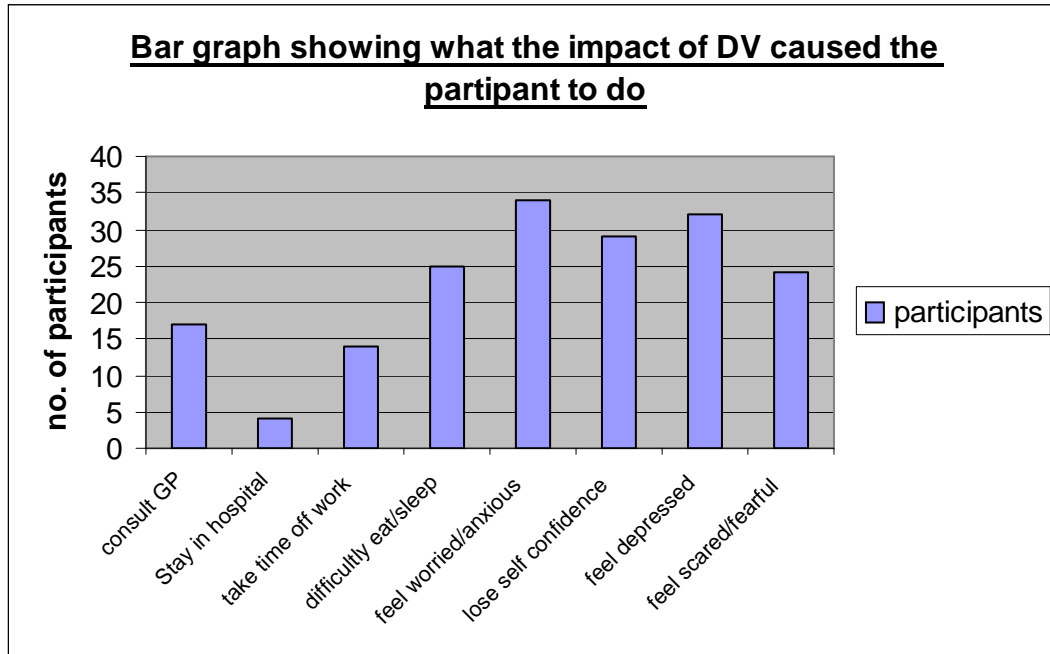
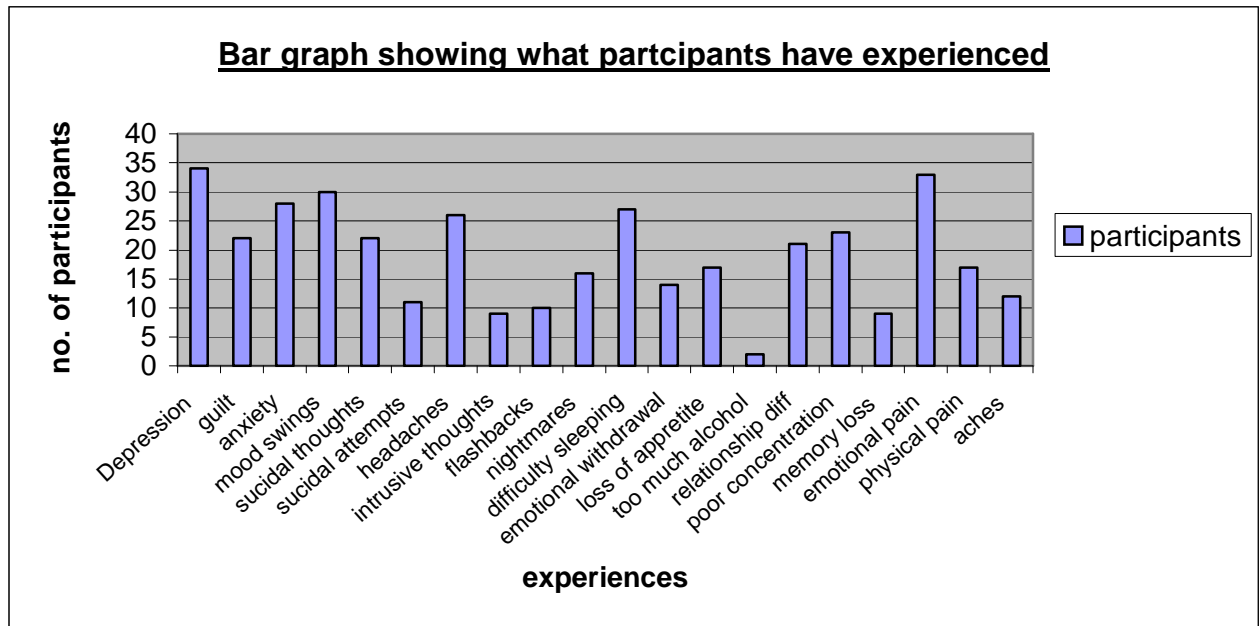


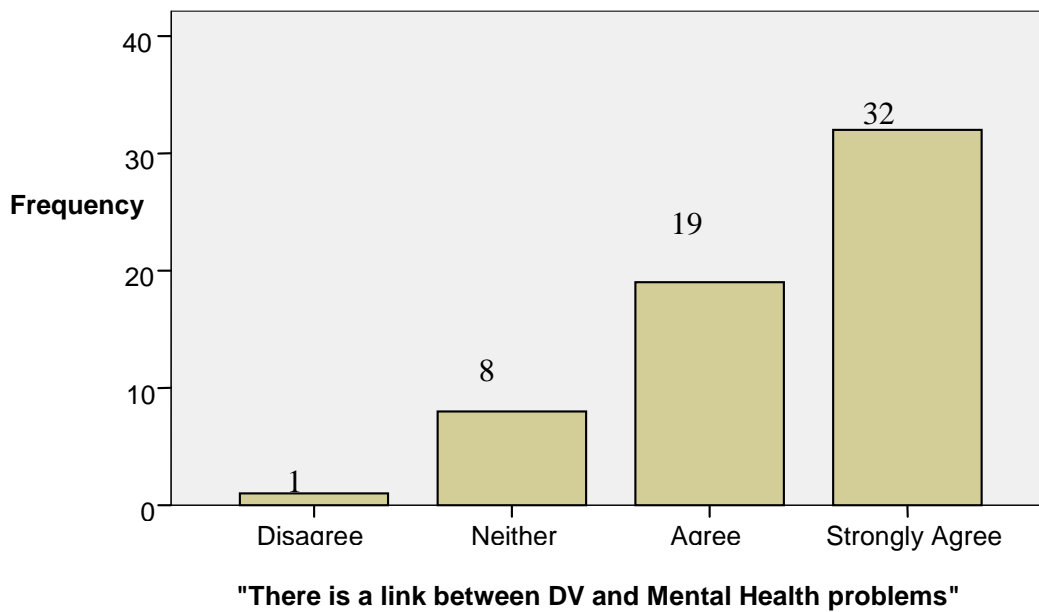
Figure Sixteen:



The research was interested to explore the perceived link between DV and mental health issues. Responses are described in Figure 14 with 83% of women in agreement that there was a link between DV and mental health. 40 participants (66%) identified a mental health problem.

Figure Seventeen:

Bar graph to show whether participants agreed with the statement, "There is a link between Domestic Violence and Mental Health problems"



The project was also interested to identify how people experiencing mental health problems sought help and support. Responses are described in figures 18 to 20. Figure 18 detailed the type of help the women would like to have received.

Figure Eighteen:

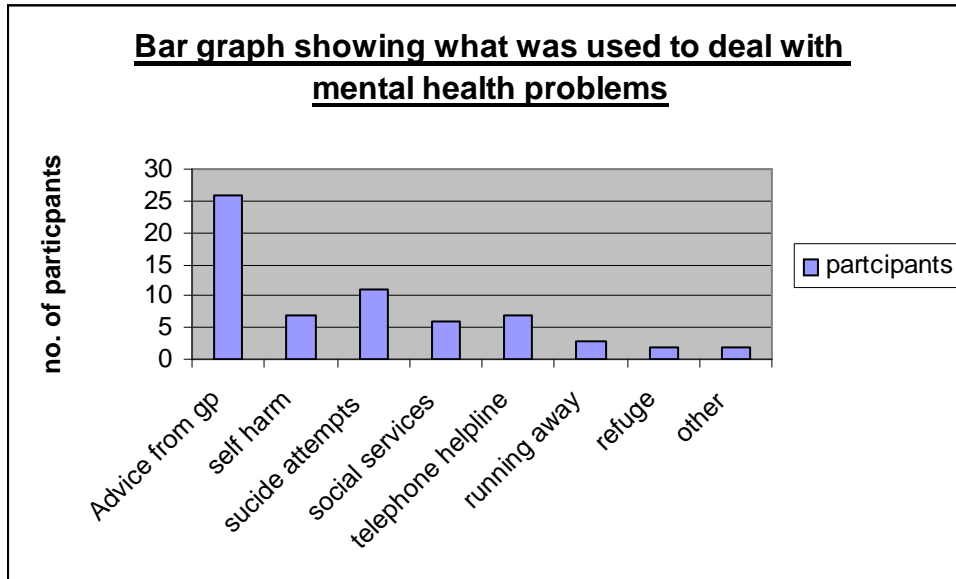


Figure Nineteen:

Bar graph to show what support/treatment participants were provided with when seeking help from their GP

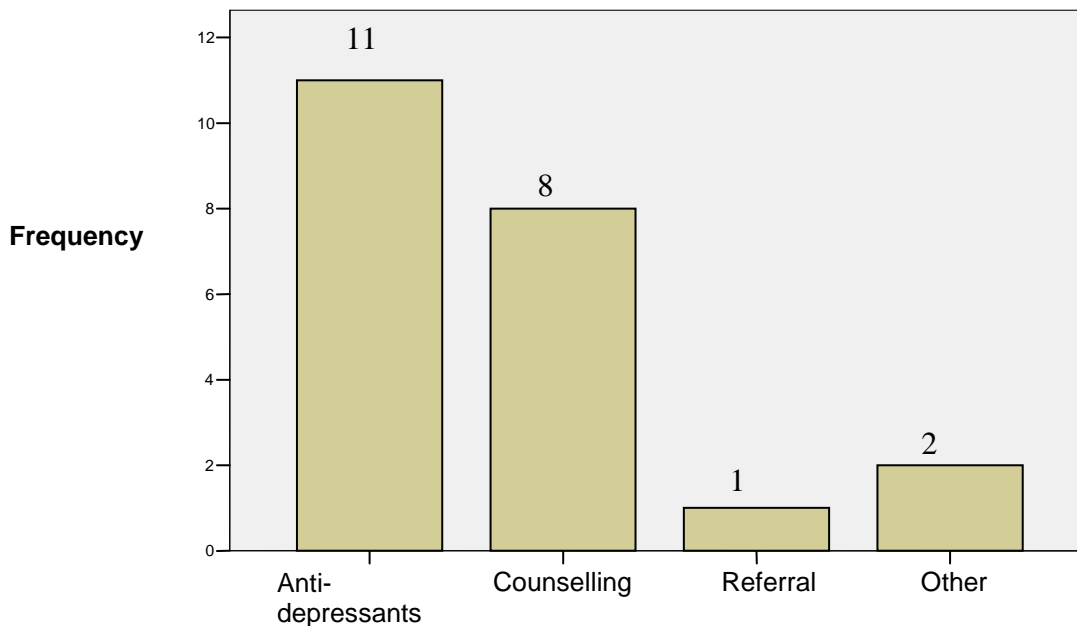
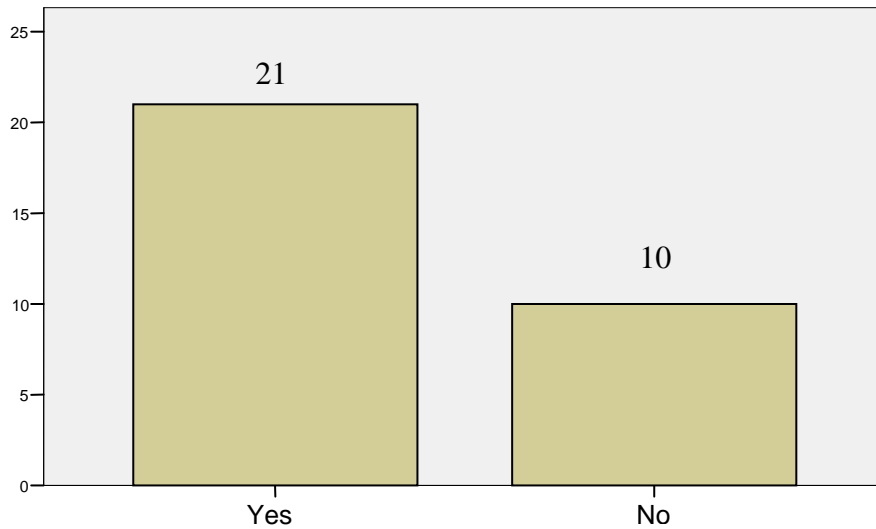


Figure Twenty:

Bar graph to show whether participants took the treatment or support offered to them by their GP



20.1 Why did you not take the support/treatment offered?

'No, I was not satisfied with GP, lack of options and understanding'

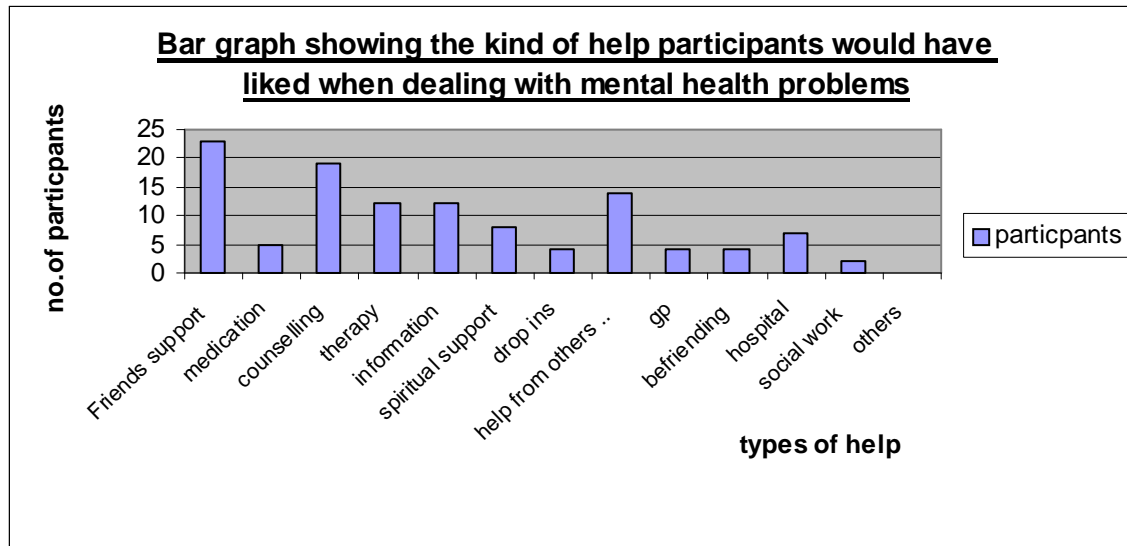
'No, was not offered any real support, just sympathy from GP.'

'Anti –depressants were offered but declined, was referred to an organisation but they did not understand me or want to help me'

'Counselling was not culturally appropriate'.

(Service User's, Kent)

Figure Twenty-One:



3.3 Immigration Status

Immigration was anticipated to be a factor for South Asian immigrants in a domestic violence situation therefore we wanted to explore the community's understanding of the topic. Immigrants often have a lack of understanding of the legal system and their rights in the UK, also the aid available for those with a uncertain immigration status can often be limited, with this in mind participants were asked "Not having a permanent UK immigration status can affect domestic violence." 62% agreed the statement was true, 35% said don't know and 3% believed this was false.

Figure Twenty-Two:

Bar graph to show whether participants agreed with the statement, "Not having a permanent UK Immigration Status can affect Domestic Violence?"

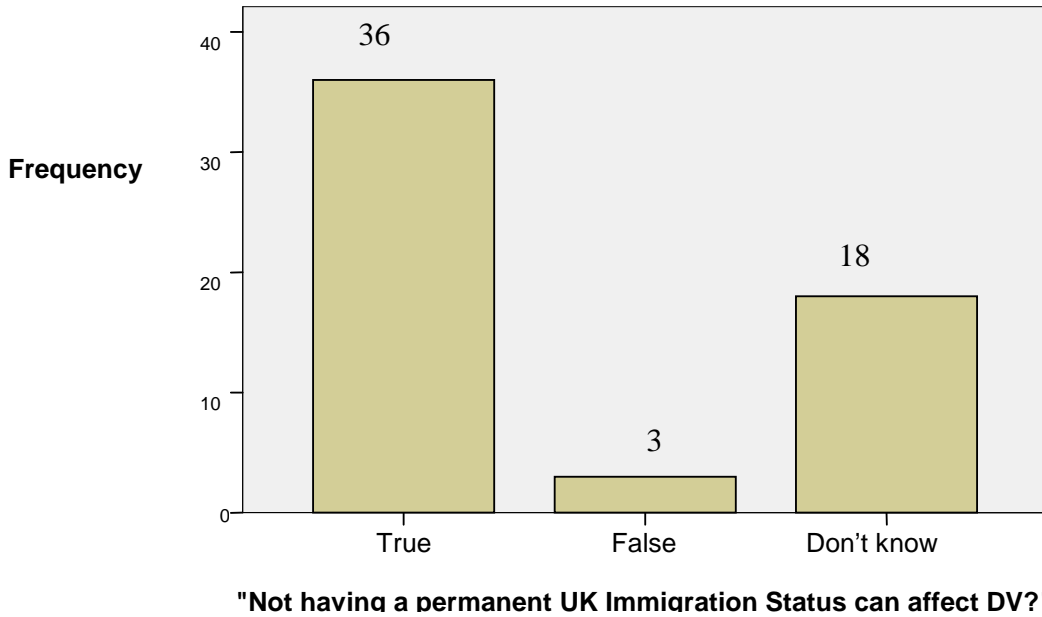


Figure Twenty-Three:

Bar graph to show whether participants agreed that "Non-UK residents are threatened with deportation in Domestic Violence"

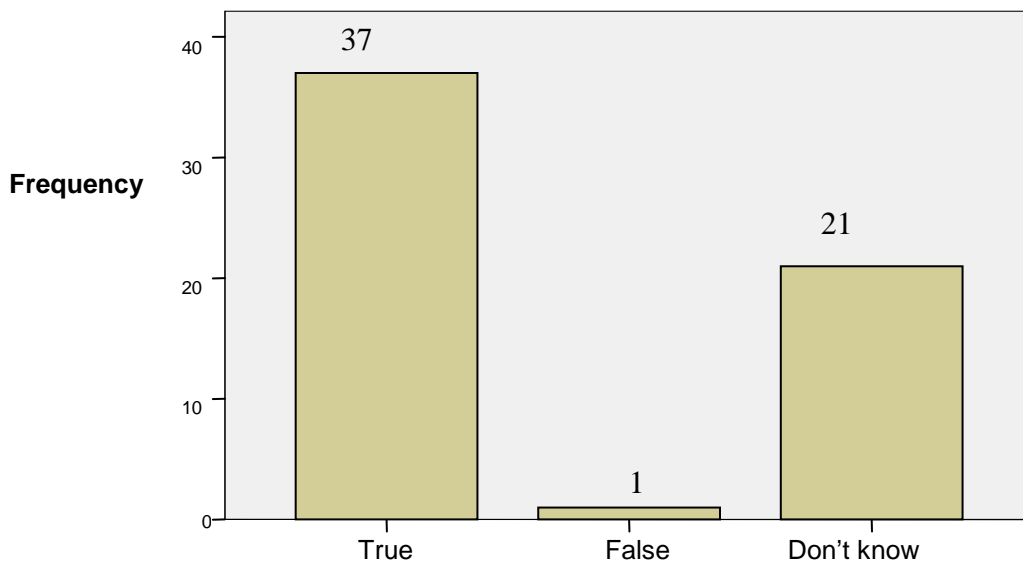


Figure Twenty-Four:

"Non-UK residents are threatened with deportation in Domestic Violence"

A bar graph showing experience of non- UK residents in home country or during journey to UK

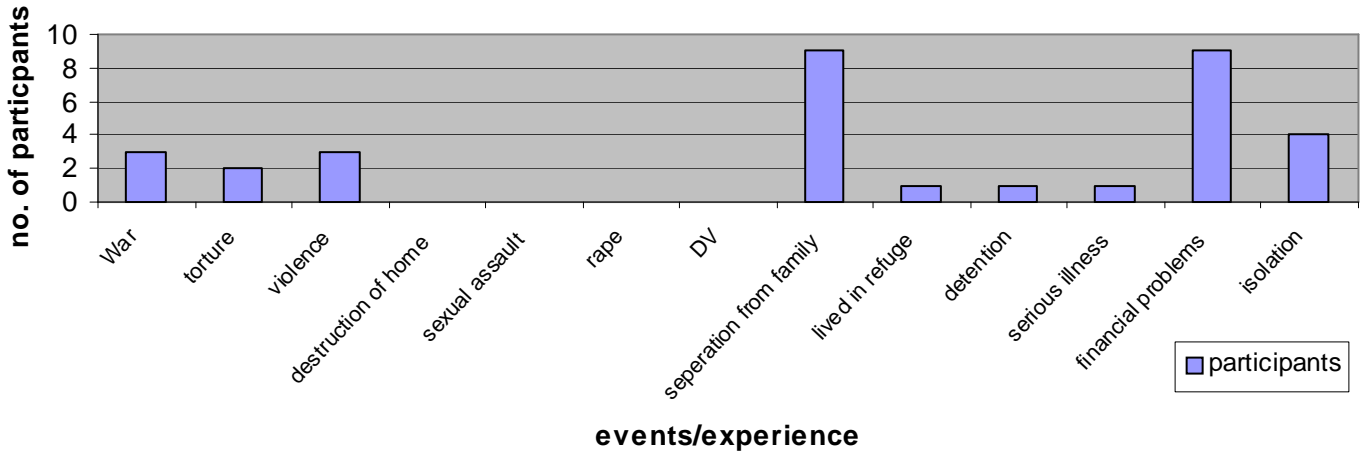
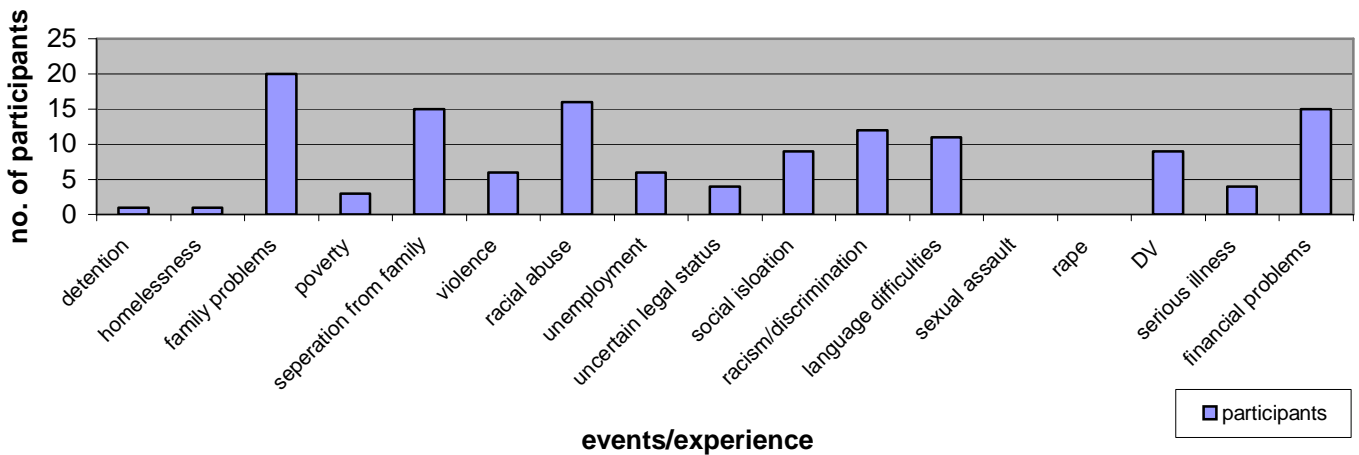


Figure Twenty-Five:

Bar graph showing what non-UK residents experienced once they reached UK



We wanted to establish who participants felt were 'responsible' for DV since the South Asian culture has an extended family tradition, therefore many issues in previous case studies have stemmed from 'in-laws'. Our data clearly shows a significant amount of participants, 17%, felt mother-in-laws were responsible for domestic violence, implying that DV is not solely caused by intimate partner, but can be another family member. It is important to also state that some participant, 8%, felt that mother-in-law was stated as least responsible, thus showing that individual differences need to be taken into account, as every situation is different.

Figure Twenty-Six:

A bar graph to show who participants felt was most responsible for causing Domestic Violence

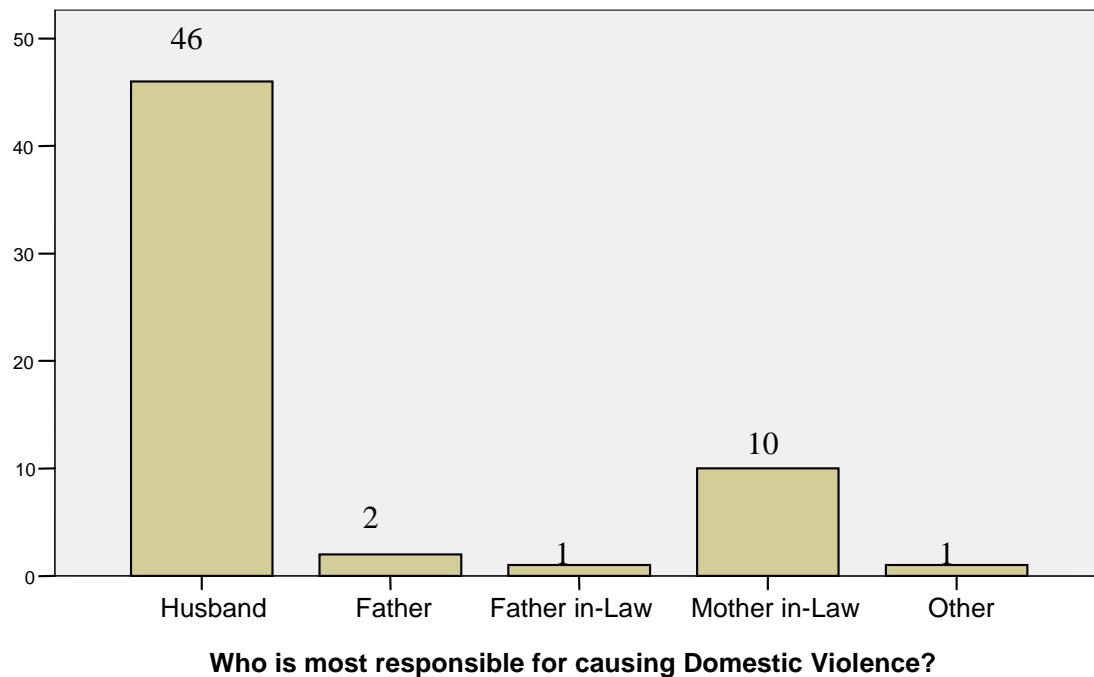
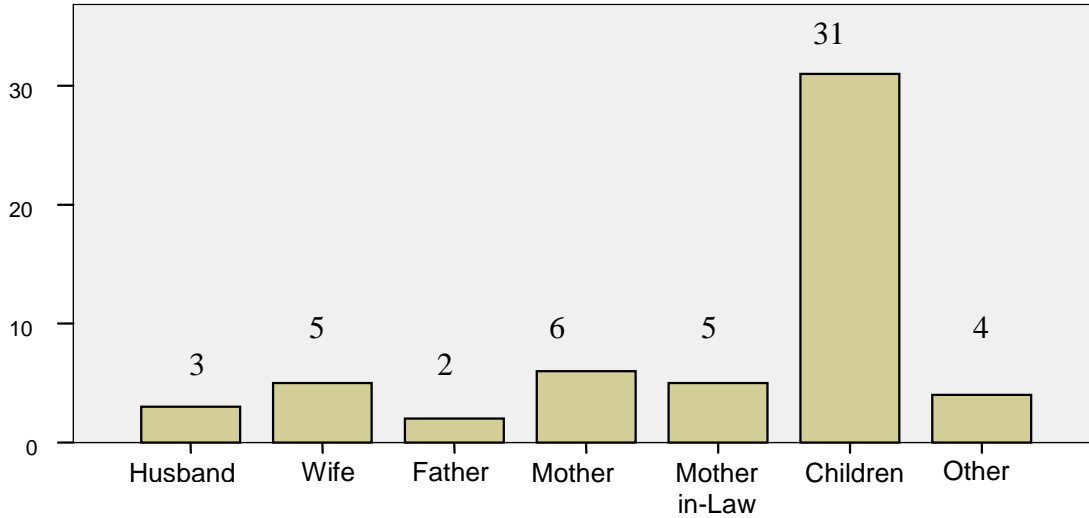


Figure Twenty-Seven:

A bar graph to show who participants felt was least responsible for causing Domestic Violence



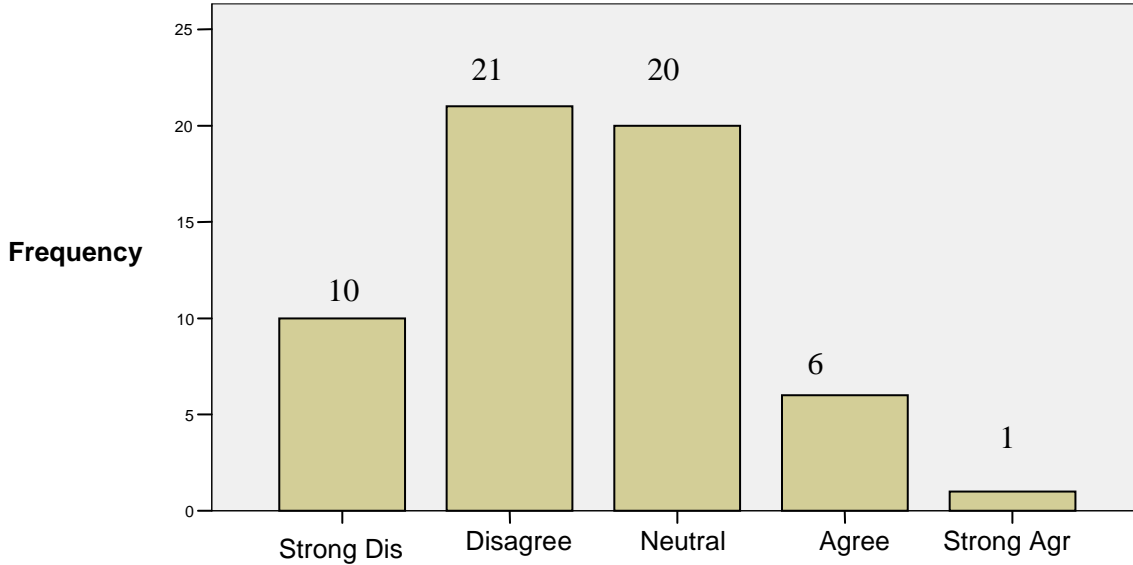
Who is least responsible for causing Domestic Violence?

3.4 Information Services

It is important that South Asian women are given the opportunity to have a mental health service that meets their needs, taking into account the linguistics, cultural, religious and issues of stigma and discrimination that can affect these groups. This section would help our recommendations since it is a clear picture of what the community feel is important as well as highlighting particular things they felt were necessary for the future in dealing with domestic violence situations.

Figure Twenty-Eight:

Bar graph to show whether participants agreed with the statement, "There are many services available for Asian women in your area"



"There are many services available for Asian women in your area"

Figure Twenty-Nine:

Bar graph to show who participants would approach for advice/help in a domestic violence situation

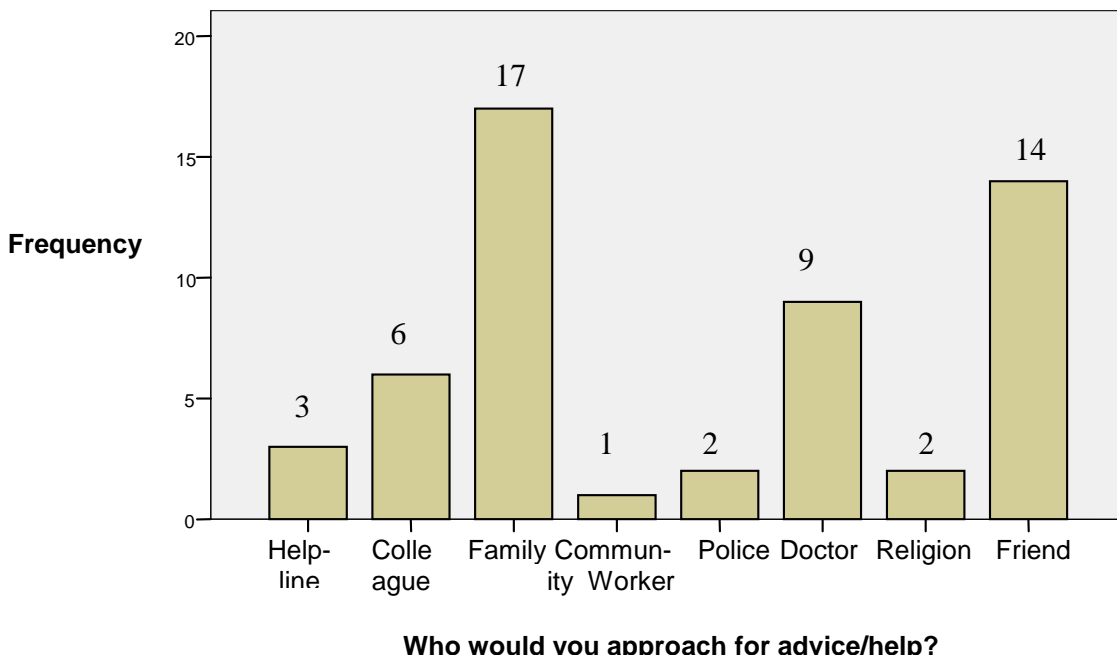


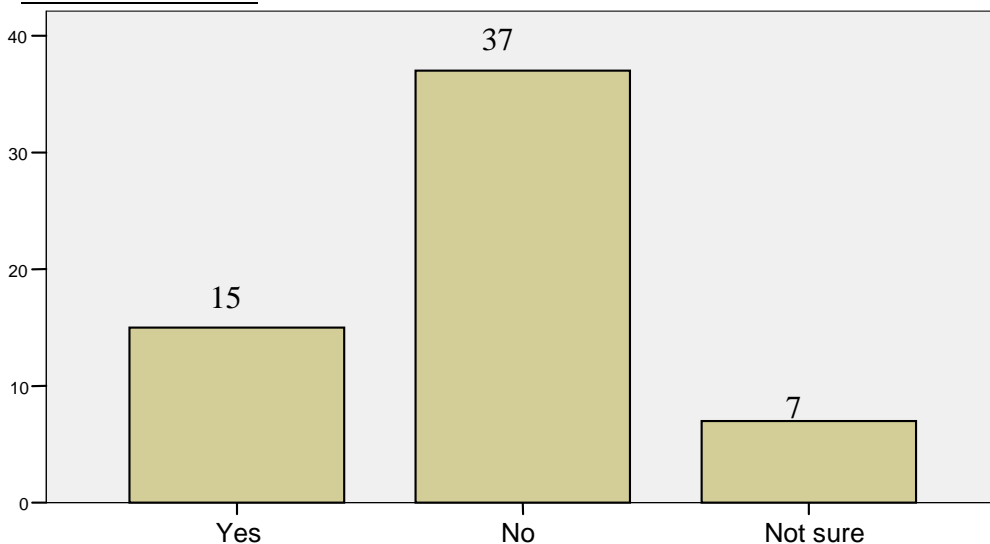
Figure Thirty:

What makes rank 1 most approachable? (Rank 1 – reason why)

- Family - *'Indians are taught to always seek advice from family first'.*
- Family – *'because the victims feel that it is safe to talk to a family member as they will keep the information to themselves, and although the victims want to confide in someone they don't necessarily want further action to be taken.'*
- Doctor – *'your doctor can be told in confidence'.*
- Community worker – *'it will be anonymous and community worker will spend time with victim and listen to them in confidence.'*
- Religious leader – *'provides me with hope and faith that things will improve.'*
- Friends – *'friends are easiest to talk to as they know you very well, this also applies to a family member, however, a family member may care too much and take action themselves'.*

Figure Thirty-One

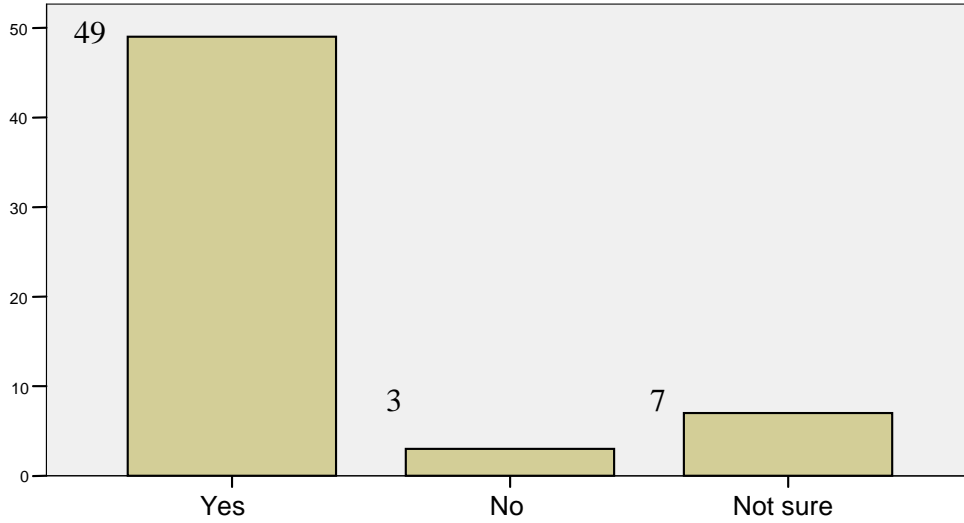
Bar graph to show whether participants were aware of any services that are specifically for Asian women



Are you aware of any services that are specifically for Asian Women?

Figure Thirty-Two

Bar graph to show whether participants felt there was a language problem when accessing aid for Domestic Violence



Do you feel that there are language problems when accessing aid for Domestic Violence?

Figure Thirty-Three

Pie chart to show what participants felt would be useful for the future

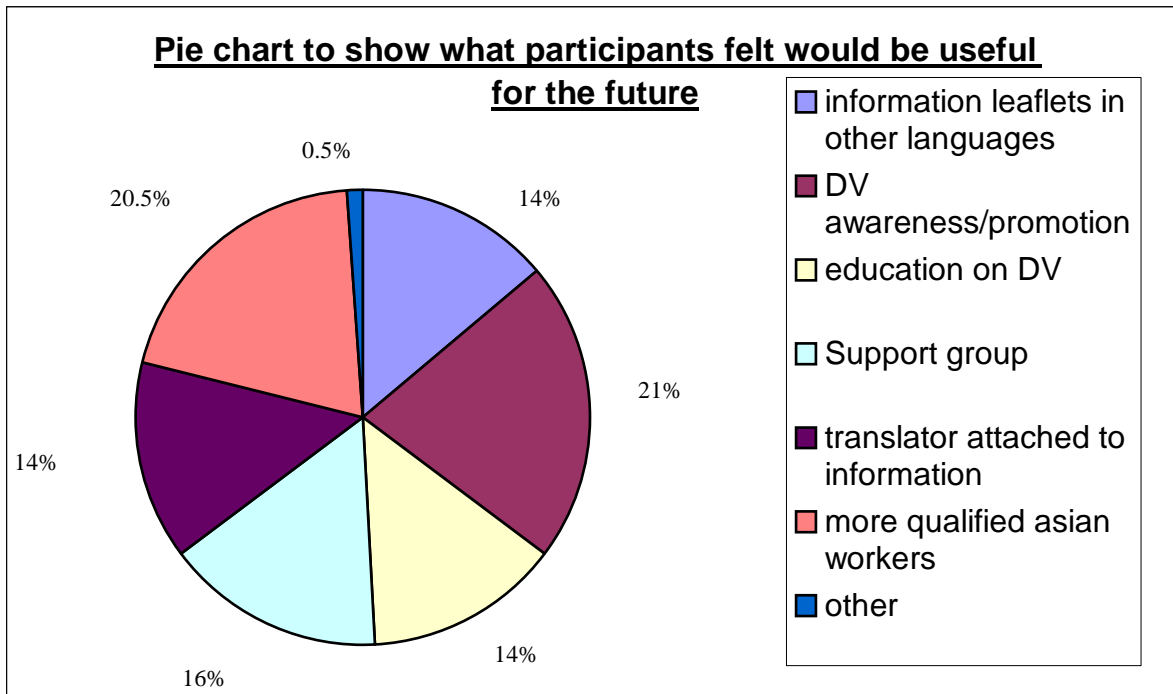


Figure Thirty-Four

34.1 Extract from Interview with Service Provider

“And what do you think the scale of the problem is with particularly Asian women?”

“Mostly the cases are girls from India who have married boys from over here and they’ve come into extended families...some mother-in-laws aren’t very nice, the girls treated like a slave. But there have been cases of people born in this country as well”

“So what would you say suffer more Non-UK or UK born?”
“More Non-UK of course.”

“... I spent a week ringing around different refuges until someone told me there is a fund available for this kind of situation (non-UK resident) and then one refuge said ‘ah no there’s too much paperwork involved, we can’t be bothered with it’ but another one was willing to do it but then the lady withdrew because things got slightly better at home so she decided to stay on.”

34.2 Extract from Interview with victim of Domestic Violence

“...to those who don’t have stamp or don’t have legal document and the biggest thing in this country is the language barrier and the only thing why people don’t come forward. And they think whatever they are going to say somebody that it won’t reach, even I have seen and heard, the interpreters don’t interpret properly”

“I never sought help because he would have never allowed me to go anywhere”

“It will only take one minute to spread a word around in Gravesend rather than tackling a problem in one night”

“Because men think that they are men at the end of the day”

“Majority will suffer. They will stay”

“Yes, well for me I easily took it that in-laws are part of marriage and joint family and that’s what you thought it is, it comes as a pack, you don’t think when you are young”

“What would you advise someone in your position with your story?”

“Get help, seek help”

“What do you think will benefit the community?”

“Awareness, defiantly, awareness in community”

“Yes the language barrier, they must learn the language.”

“Awareness of rights.”

“What to you is domestic abuse?”

“Abuse is abuse isn’t it, physical is worse than mental (0.03) but if you are mentally upset life is hell, so life is hell”

“Have you suffered?”

“Mentally I have been upset.”

“You know in older times they used to say women have no rights, men rule and men is the only person of the house, set you know ways.”

“Depression I went through, bad, bad, severe way”

SECTION FOUR: DISCUSSION

4.1 Participants

The first section of our questionnaires asked for personal information from the participants. We didn't ask for any names from individuals to keep anonymity, but general details are necessary in research so we can understand who from the community we have participating and to ensure we have an even spread. The aim was to involve all ages in the research because domestic violence is an issue that can affect women of any age. We did not target only service users but attempted to involve all women in the community to ensure representative data, however the majority of our data was targeted therefore not an accurate representation of North West community.

Our data indicates that the age ranged from 16-50+ years. The majority of participants fell in the age bracket of 40-49 and 25-29 with 23.3% and 21.7% respectively. The other age ranges were almost equally distributed, showing that there was a reasonably even spread, thus allowing the findings to be generalised across all ages. The smallest group of participants were the 50+ group with only 4%. To overcome the lack of 50+ participants we went to a service user's forum and held an informal discussion on domestic abuse, and this was a significant perspective to capture in our report given that we anticipated their views to be different because they are older and today many are in-laws so the perspective would be different. The focus group allowed us to draw out the service user's opinions, and incorporate them into the overall findings.

All the participants that took part in this study were female, which was the population sample we decided on, and all participants were heterosexual. When looking at ethnicity, participants were mostly from a Punjabi and Indian background with a majority of 53% and 20% respectively. Other ethnic groups such as the Bangladeshi, Pakistani and Gujarati groups also took part. When looking at the cultural spread within the North West Kent area, it can be said that these findings are representative of the population within that region, as national statistics (2001) show the residential population percentage of Indians in Gravesend are 7.19% compared to South East percentage of 1.1. As established at the beginning, concentration was to be placed on the South Asian population, for this reason the ethnicity group gathered is not only suitable but representative of the area under investigation. The religious backgrounds of the participants are in accordance with their ethnicity, therefore it can be no surprise when 63.3% were Sikh, 20% Muslim and 16.7% Hindu. Being the three main religions in South India, these results appear valid.

At the initial point of collecting data it was established that in order for the results to be representative of the South Asian group within the area, the results needed to portray opinions of both Black, ethnic minority (BME) citizens born in the United Kingdom as well as those that hadn't. This allows us to assess whether opinions differ among the two groups, implying that differences of being brought up in the UK

may change perhaps a more traditional/cultural way of thinking. The pie chart shows that there is almost a 50/50 split of UK born participants and non-UK born participants. Therefore, it can be said that the results can be generalised across both groups and the opinions given are representative of both backgrounds. When looking at citizenship it can be seen that the majority of participants are British citizens (78.3%), about 46.7% of that statistic are British born and the remaining through other means, such as naturalisation. The rest of the participants were as follows, 11.7% held refugee status, 8.3% with extended leave and 1.7 with no status.

Further establishing the background of the respondents the majority were married/cohabitating participants. These people stated they lived with their husbands/partners, children and/or in some cases their extended family. Single people were the next most popular group, whom mostly lived with their parents, a few lived alone. Although not as vast in number, separated people were next most common, followed by divorced then widowed people, these individuals either lived with their parents, or their children. A low number of divorced participants can be seen as a reflection of Indian culture and traditions that you 'plough through' and only divorce if circumstances are extreme, as it stated in the introduction a South Asian woman's respectability, honour and status are dependent on her marital status, therefore it can be believed that South Asian women only divorce as a last resort. One participant when interviewed stated,

"You are brought up to not think that way, you don't consider leaving",

When asked why she didn't leave her abusive partner. Overall we have a majority of married participants and a substantial number of single individuals also and it is interesting to have both views since we do expect a difference in their opinions considering their experiences of life and relationships may differ a great deal.

When looking at marriage, it was important to understand how the participant's marriage had taken place, as the South Asian culture has a tradition of arranged/assisted marriage. Arranged marriage is whereby parents and elder family member aid in finding a partner, it was interesting to analyse whether this is still a popular method of marriage across the ages and if the majority had married this way. Arranged marriages were by far the most popular method of marriage as 78% of the participants were married individuals, this is a significant finding. Not all marriages were arranged therefore we added the category 'love', which would be understood as the participant had chosen the individual they married, a marriage of choice – fell in love before commitment. Love marriage was the second most popular option but this was only 17% of participants. 'Assisted' and 'forced' would still come under 'arranged marriage' but since many do not have any choice (forced) and others have a lot of freedom in their decision and meet their partners (assisted) we wanted to show this difference in our report. Overall arranged marriage was clearly the main way married participants met their partner.

4.2 Findings

We used Statistical software for social sciences (SPSS) database to analyse our quantitative data and to output our results.

Once the results were gathered one of the first and perhaps most vital things that needed to be assessed were whether the target audience believed that “domestic abuse is a big problem in most Asian households”. When using a five point Likert scale, with options of “strongly disagree”, “disagree”, “neutral”, “agree” and “strongly agree”, participants were asked to rate their belief. The graph shows that the majority of people agreed and strongly agreed to the statement. The adverbial of degree ‘most’ in the statement makes clear that we are not stating in all households domestic abuse is a big problem but it is prevalent. A fair amount of participants felt neutral about the statement but a few disagreed with this statement also.

We then compared UK and non-UK born citizens, to judge whether the same belief was shared. Despite the geographical differences in their upbringing, both sets of participants agreed and strongly agreed that domestic abuse is a problem in Asian households, only eight out of all participants in both groups disagreed. Similarly among the diverse age groups the vast majority of people agreed to the statement. A small proportion in the 19-21 year olds disagreed showing that perhaps thoughts and beliefs are diluting with time and a generation gap is present.

One of the crucial questions within the questionnaire was whether the participant had personally suffered from Domestic Violence. The findings linked to our hypothesis that the majority of 55% had, which is just over half our 60 participants have suffered a form of domestic abuse. Approximately 40% had not experienced domestic violence and a small minority of 5% was ‘unsure’ of whether they had. This appears to be a substantial finding as we had anticipated that domestic violence is prevalent within the Asian community. One of the key limitations of our study is that it is difficult to reach severe sufferers of Domestic Violence since they do not communicate to services and may not feel ready to come forward, we only could approach the population of the community who had links with services or were working women and also those who had access to the English language; questionnaires were kept simple but were in English so many could not fill out without assistance and therefore declined. Therefore our sample was targeted, majority of participants are women who have already come forward.

In order to establish why the population samples who are in a domestic violence situation did not seek help we asked whether they felt ‘shame’ (*Sharam*) getting outside help since it is a common part of Indian culture. A large majority of 73% agreed with this statement but 20% did not feel this was the case and remaining were unsure. Since the concept of ‘*izzat*’ (honour) is abstract we wanted to understand individual definitions, we therefore gave the opportunity to elaborate on the concept of “*Sharam*”. We found a striking similarity in the responses from

‘Yes, on the outside Asian families try to convey they have a happy and fruitful loving family life. By getting support it is considered to break that ‘illusion’ and admit problems exist, thus, causing shame in the community’.

participants who agreed ‘izzat’ is a big deterrent in accessing services. One individual stated that

This idea of upholding family honour was a persistent theme in participant’s beliefs. Another participant stated that

“... It’s public humiliation, the Asian community are judgemental”, followed by another individual who felt, “Problems should be kept in the family and to involve outsiders is considered shameful”.

The idea of seeking help for a Domestic Violence situation as we anticipated is seen as having a stigma attached to it. It is considered a declaration to the community that they don’t *“have a happy and fruitful loving family life”* therefore *“...community will think less of them”*.

The concept of upholding family name and not being judged by other Asian communities wasn’t the only the reason participant stated for believing that there is “shame and dishonour” attached to getting help for Domestic Violence. Other participants suggested that cultural expectations, upbringing, society and gender roles played a part too. One participant stated that

“Men are taught they are better than women therefore problems occur and women can’t speak for sake of saving family disgrace.”

This not only highlights gender differences, that men are superior to women, but also emphasises the importance of family name. This quote also brings forward the power structure of South Asian families where a woman’s role is seen hierarchically lower than a man, as one participant explained why so many suffer in silence,

“...because men think that they are men at the end of the day. Even some educated girls from India still they are under their, not thumb but it’s the culture that puts them (0.05) in a state they can never say”

This outlines the framework of the culture that one must not speak against their spouse and it is taught to many women of this culture and it’s something which is still strongly believed and can be the underlying cause of Domestic Violence. Many Indian men maybe think it is alright to talk to their wives in a certain manner because they have ‘learnt’ that it is acceptable behaviour and women do not speak up maybe

because they accept this as what is supposed to happen. This theory is supported by a statement made by another participant;

“Most of the victims of this abuse have been brought up with traditional old-fashioned values, therefore feel that they have to put up with this abuse and should not complain or seek outside help”.

Followed by another participant who expressed;

“It is made to be a woman’s duty to accept everything in a marriage and to believe things will get better as life moves on”.

Here it can be seen that there is a persistent theme of gender difference, which has been learned through cultural upbringing. It appears that women in Asian families are taught to be subservient and accept all that a man does for them, from this men can be perceived as the dominant ones.

For those who had experienced domestic violence we wanted to establish how long this had been going on for. Most had been in a domestic violence situation for over five years, very few had it begin within the last year, this is in correlation with the age range, the majority who have suffered Domestic Violence are 25 plus therefore in a marriage for five years and many more years. As researchers, a limitation in our findings was that the frequencies were not spread out enough, by stating five years plus on the scale and not expanding the length of time, a large majority of sufferers are grouped together, whether they suffered for five years, 10 years or their whole lifetime. However, what can be said is that these Asian women for a substantial length of time have suffered Domestic Violence.

An important issue within the research project was the link to mental health, as anticipated as an effect of any trauma, mental health will be severely affected. Respondents were asked whether they believed “there is a link between mental health and DV”. Fig 21 illustrates over half our participants strongly agreed that there is a link between domestic violence and mental health problems. The general consensus was to agree with the statement but a marginal amount of participants were unsure of the answer and a very small minority disagreed. Therefore, a strong link is suggested between mental health problems and domestic violence, which was anticipated as Kumar’s (2005) India based study showed a direct link between domestic violence and mental health illness. Mental health is hugely affected by domestic violence; this link is further strengthened through our research. (Below evidence from interview with DV sufferer, see appendix 1 for full transcription)

I: What to you is domestic abuse?

A: *Abuse is abuse isn't it, physical is worse than mental (.) but if you are mentally upset life is hell, so life is hell*

I: Have you suffered?

A: *Mentally I have been upset."*

As can be analysed from the above extract there are many forms of Domestic Violence, mental and physical are two of the most recognized and severe since they can internally scar you and over time have detrimental effect on your self-esteem and self identity. We needed to explore this understanding in our research and since some forms of Domestic Violence are not so obvious such as financial or emotional for example where a woman is not allowed access to any money and must ask her spouse if she needs any finance. Therefore it could be assumed that some individuals could be suffering from less obvious forms of Domestic Violence without being entirely aware of it and oblivious to the idea of seeking help for it. For this reason, participants were asked what people associate with Domestic Violence. The results from our data show that large majority of participants consider physical, emotional and verbal as Domestic Violence and sexual, alcohol and family pressures follow this closely. Interestingly majority of participants felt physical and emotional abuse is equal showing a good understanding of Domestic Violence and awareness that verbal abuse can be just as harmful as physical. All in all, it can be seen that participants agree that all of these areas are associated with Domestic Violence in one form or another. However immigration and economical abuse were significantly lower than the other forms of association, this could be due to a lack of clarity – people not understanding that immigration abuse is when being not permanent UK resident is used against you, or it could be that this is not been considered as a cause but more an effect. It is interesting to see that physical and emotional abuse is equal therefore people do recognise that mental health is linked with Domestic Violence. These findings showed that the South Asian population in North West Kent are largely aware of many forms of Domestic Violence and have a good understanding of the different types.

When Domestic Violence sufferers that participated in this study were asked what they had experienced, depression and emotional pain were the most common experiences as a result of Domestic Violence. Difficulties in sleeping, concentration, and anxiety, mood swings were also common features. These seem to show that there is a definite impact on the mental health of the individual suffering and also that participants had an understanding of what their mental state was like, under distress. A very small minority sought any help despite awareness that the symptoms they were suffering were forms of mental illness. It can be suggested that the reason individuals don't seek help can't be because they are unaware of their symptoms. Instead, perhaps it links with the idea of family 'honour' (izzat) causing them to keep quiet, as established earlier, or fear of disappointing their family. Through the interview with a victim of Domestic Violence who had suffered mental abuse we discovered that seeking help was not an option to her...

I: So what effects were on your mental health, specific symptoms?

A: *Depression I went through, bad, bad, severe way*

I: Did you seek help?

A: *No I was in such a bad way, he [Husband] couldn't even understand what it was, he still doesn't know what it is*

I: Did you know it was depression at the time

A: *No I just pulled out because God was watching me somewhere, he was the only one, otherwise state I was in I would have never pulled out*

I: That bad? Did you..[

A:] *I never seeked help because he would have never allowed me to go anywhere*

I: Not even doctors

A: *No...*

The options participants had for 'what symptoms they suffered or actions this caused them to take': "consult general practitioner (GP), stay in hospital, take time of work, difficulty sleeping, feeling worried/anxious, lose self confidence, feel depressed and/or feel scared/fearful". The most common result of a Domestic Violence situation seemed to be feelings (mental well-being), mostly of being worried and anxious, but also depression, loss of self-confidence and being scared and fearful. Of those that suffered, a considerable proportion of people did consult their GP, consequently showing that it is an important tool for Domestic Violence sufferers. This corresponds to the prior belief that mental health is linked with Domestic Violence, but this data has also brought forward general practitioners as an important source of support for Domestic Violence sufferers.

Looking further into the role of the GP, respondent that had suffered from Domestic Violence and sought help from the GP were asked what support/treatment they were provided with. Anti-depressants was the main option given, followed by counseling. Majority of participants were happy with the treatment provided however complaints were that the waiting list for counselling was too long and many others were not given more than one option. Worries about addiction were also present. The next graph however goes on to show that only half took the treatment that was made available to them. The reasons individuals did not take the support/treatment offered, one common failure in the eyes of the participants was lack of knowledge, understanding and aid from their GP, one participant said,

"I was not satisfied with GP, lack of options and understanding", and another said, "I was not offered any real support, just sympathy from GP".

Here it can be said that for those individuals who did take the step to seek help from their GP's were left unsatisfied. With no resolution in sight, the worry is that these women didn't seek help elsewhere. Perhaps with a more positive outlook from the GP participants would be more likely to take support/treatment required. One particular respondent stated that she '*... was referred to an organisation but they did not understand me or want to help me*', and another said,

'Counselling was not culturally appropriate'.

This is a key quote from our research, 'culturally appropriate' service is one of the main things lacking for the community, if your culture is not understood, and then a part of that person, and their background and problems cannot be understood. This lack of understanding is a gap that needs to be bridged as the DRE (Delivering race equality) action plan states in point 3.30

'Inside Outside, its consultation responses, the Mental Health Act Commission and the inquiry into David Bennett's death have all highlighted the need for improvements in the ability of mental health staff to deal with different racial and cultural groups' (page 43).

This shows that there is already an understanding within the mental health field of a lack of cultural understanding and this report provides further evidence of that.

It is interesting that the GP is a common first step, the reason most probably is doctor-patient confidentiality and access is also another reason, it is easy to create an appointment with GP but not to access an external service for people in a vulnerable position hence why signposting is essential for these women to become aware of other services.

To explore further who participants would turn to, we asked who they (hypothetical, if not a sufferer) would approach for help, in a Domestic Violence situation. 38% of participants would talk to a member of their family or seek advice from a friend before approaching any service. This shows that services are secondary; a relation, someone familiar and other elements such as confidentiality and trust are clearly of importance. The first service that would be accessed would be, as we anticipated, general practitioner, which links previous data collected, and the primary reason for this was doctor-patient confidentiality, thus reinforcing their importance. Some individuals would turn to a work colleague or a helpline; this could be due to them being external to situation and an outsider view. 23% of participants would like help from others in same position, this is an important opinion and encourages more service user involvement in improving services. People can feel intimidated or judged by a health care professional but when you meet a 'survivor' of domestic abuse or someone who is going through a similar experience it can strengthen you and take away a sense of isolation; therefore it is an important viewpoint.

Police and religion would also be sought by a small amount of people but most decisions were based around turning to people who know who you were, family or

friend. Religion is a large part of Indian culture and many people seek help at their place of worship before anything else. Strong evidence for this came from the interview where the participant stated,

“...I used to go temple and cry all the time and I felt strength building up and it's the only thing keeping me going even today”.

For North West Kent their places of worship are the main place for the community to gather on festivals and celebrations, for this reason, it can be seen as a key area to communicate to the community and a great place to educate. There was a lot of cynicism about places of worship too since there have been bad experiences captured,

I: So when you mention community, what is different about Asian community..? [

A:] Asian community is not just two faced I would say I can't tell you how many faces. Even some religious people are not very faithful. They can create problems but never solves problems; it will only take one minute to spread a word around in Gravesend rather than tackling a problem in one night

The participant was asked to elaborate on this...

I: Is this just Gravesend or is this the culture?

A: It's the culture; it's all round its all round no matter where they go. It's the mentality.

This extract emphasised the problems of being a close knit community, many people worry about the community knowing their family issues and the 'izzat' factor once again seems to play an important part. While for many places of worship are salvations where they can interact and socially meet people from their community and for others it can be very isolating if they are not accepted.

An important issue to address in a Domestic Violence case is establishing who is 'most responsible' for causing the situation. When asked, participants stated that the husband was seen by a very large majority as the most responsible for domestic violence, as shown by Fig 31 and after a large gap the mother in-law was seen as second most responsible. The individual's father came third followed by father in-law, showing a large male dominance in causation. A small minority stated other as responsible, pointing towards another individual in the extended family as a cause for domestic violence. Individual differences need to be considered since every situation is different. It was anticipated by researchers that the husband would be seen as most responsible, and a mass 77% of the respondents agreed that the husband was 'most' responsible for causing Domestic Violence. However it was

interesting to see in-laws also to be highlighted significantly by participants with 18% believing they were responsible for Domestic Violence. This links with the Indian culture and traditions and many would say the joint family system is the reason behind this as one participant commented,

“I easily took it that in-laws are part of marriage and joint family and that’s what you thought it is, it comes as a pack”.

Many South Asian women live with their in-laws and the culture has a hierarchal structure, therefore one is taught not to question or go against an elder in the family and the basic structure forces one to feel powerless, this can be the reason behind this finding.

When asked who is ‘least’ responsible it can be seen that the participants considered children to be blameless in the situation, followed by mother. The wife herself and mother in-law were also seen as least responsible in a domestic violence situation. Mother in-law was by a large number of participants, also seen as most responsible, this result shows how each situation is unique and varies, and the causation factor is dependant on the household. The husband has also been suggested by a small minority as least responsible, this could be an indication of the individuals blaming themselves or another member of the family could be the cause of the domestic abuse experienced.

An important element in the project was the idea that an uncertain immigration status can affect a Domestic Violence situation. When participants were asked this, they stated that ambiguous immigration status can prevent individuals seeking help and can also be a factor that creates a domestic violence situation since knowing the girl is not a permanent UK resident, the families can have a sense of power over the girl and create a domestic situation. Majority agreed that this is a significant factor, but a small minority disagreed with a fair number of participants unsure, this could be due to the lack to clarity in the issue and people not having enough information on immigration law.

To further understand the difficulties of those who leave their country and have to settle in a place where everything is ‘alien’ we asked participants about their non-UK and UK experiences. Separation from family was the main experience followed by financial problems and isolation. Comparatively in the UK the main experiences, in order of most common were family problems, racial abuse, and separation from friends, financial problems and language difficulties. Family problems are a common problem but it was interesting to see that racial abuse had been experienced by 64% of the participants who answered that question (25 participants).

Looking further into immigration, participants were asked whether “non-UK residents are threatened with deportation”. The results showed that over half of our participants agreed that deportation fear is a large issue for non-UK residents. 27% were unsure of this statement, once again this could be due to the lack of information available to them about immigration issues or lack of clarity in our explanation. A

small minority disagreed with the statement. From this it can be seen that uncertain immigration can not only act as a trigger for Domestic Violence, allowing perpetrators to use it as a threat, but legislation also makes it difficult for sufferers in this position to attain help due to policies that can prevent them accessing aid. When interviewing a Domestic Violence worker from West Sussex County Council regarding immigration, she stated that

“Language barriers, lack of knowledge and immigration status can affect whether or not they access services. They are told if they reach out, it could lead to deportation.”

It can be seen that not only are women with uncertain immigration status at a disadvantage because they have language barriers, but their lack of knowledge in services and legislation make them more timid in reaching out and accessing help.

One service provider went into detail regarding a Domestic Violence sufferer with uncertain immigration status,

“I have dealt with clients who were given two years of leave to stay in the country on marriage grounds. These women were facing Domestic Violence and it was difficult for them to access the services or to make up their own mind.... They had no alternative but to suffer in silence till their immigration status is cleared”

For those that suffer from Domestic Violence and those that don't alike, we wanted to establish whether the North West Kent South Asian population was aware of any services that were available to them as specifically Asian women. Respondents were asked to give their view on the statement *“there are many services available for Asian women in a Domestic Violence situation”*. A large number were unsure of whether there are many services available, this in itself is an indication of the lack of awareness or lack of promotion of services in the community. Many disagreed with there being many services and a small number of individuals agreed. This is reinforced further when a majority of participants disagreed that there are services available exclusively for Asian women but a fraction were aware of certain services, namely Rethink–Sahayak. This outlines that most of the community are unaware of the services around them and also would therefore not know how to access them.

For those Asian women that did suffer from Domestic Violence and did seek help, it was asked whether there was a language problem in doing so. Nearly 50 participants, 83%, agreed there is a language problem in accessing aid, this links with the lack of understanding of BME specific services where bi-lingual workers would be present. A small minority were unsure of whether there was a language problem, this could be since they themselves have not had a need to access a service or are bi-lingual therefore never been in a situation where they felt this is a

problem. Overall a language problem in accessing aid is present for our population sample. Language can be seen as a major barrier in an immigration problem; alongside needing to access a service since communication is vital,

“...those who don’t have stamp or don’t have legal document and the biggest thing in this country is the language barrier and the only thing why people don’t come forward. And they think whatever they are going to say somebody that it won’t reach, even I have seen and heard, the interpreters don’t interpret properly”

This is a striking quote from the interview that took place with a participant, since this was part of a real life account and first hand this participant witnessed the language Punjabi, which is the predominate language for our participants, being translated incorrectly. This can be the difference between a woman being granted a permanent legal status since if her case is not being put forward accurately vital information can be lost. It is unfair for that individual and shows a large problem, as many do not come forward if they do not know English. Even for our research many did not want to participate because they did not know English, despite researchers being bilingual and willing to translate, many were intimidated. If our questionnaire had been translated into Punjabi and Hindi, the two main languages, we may have reached more participants and this was a limitation in our design. Our participants were mainly English speaking and writing but more spoke than wrote in English. This implies, for example, that the BME group may have difficulties in accessing literature like self-help leaflets. This was reflective through all languages; individuals were more capable of speaking different languages than writing them. The four most popular languages to both speak and write were English, followed closely by Punjabi, then Hindi and Urdu. This seems logical, as they are the most common languages spoken in South Asia.

Above is the simple analysis of the data we collected which has allowed us to draw on certain points which were highlighted by a significant number of participants. Non-UK born citizens have to deal with many issues that have been mentioned above; the main two things are immigration issues and language barriers. The latter problem stops these individuals in accessing and communicating when in need and therefore more options need to be developed for this vulnerable sector (see recommendations). The majority of participants did agree that not knowing the legal system and being unable to speak English is what causes isolation and this can lead to severe mental health problems such as depression. The extract below is from a participant who was born in India but was able to come here young enough to learn the English language and understand the law:

I: Do girls from India have it harder than girls from here?

A: *Oh yes!*

I: Main difference?

A: *Kids brought up here know the system, only 10% don't allow their kids to be brought up in English culture but Indian girls have it hard. "*

Education is essential for the North West Kent community and especially there is a need to educate those who do not speak English since acquiring information will be most difficult for those individuals. The men also find it difficult and they also need to be educated since being considered the 'most responsible' for Domestic Violence they need to learn what is acceptable behaviour and also they will benefit from knowing there are services available to them too.

Accessing a service is not the first option for the majority of North West Kent since someone they know, friend or relative, would be consulted first. The first option outside the home was to see a GP, and the main reason behind the popular options was because of confidentiality.

I: Do you think people will reach out to services when in problem, is it an option?

A: *Will the family, I mean if she is going through bad patch I don't think family will allow. That is the culture, the culture again*

I: What if family are the abusers...]

A:] *Very few will, majority will suffer. They will stay [In Domestic Violence situation]*

'*That is the culture*', that is the most striking part of the extract above because the quote states acceptance of suffering and states this as a fact that is not flexible, it will remain the way it is. That is something one cannot change currently, the mindset of the South Asian community and their upbringing, which has taught them certain principles that they must adhere to. The concept of 'izzat' which comes before you and your happiness may seem absurd in western society but it is a very real part of South Asian culture and perhaps it may be diluting through the ages and generations but is still very prevalent.

In conclusion, we have seen in some detail how powerful traditional concepts such as *Izzat* and *Sharam* have historically informed and reinforced patriarchal views of female behaviour and modes of conduct such as accessing help when needed. However, it is important to understand that such concepts do not always have a negative effect on people's lives, indeed many South Asian women live happily and reconcile traditional cultural values with modern ways of understanding.

We have seen through the data we have collected that, lack of information around immigration processes and rights, traditional concepts such as Honour and Shame, lack of engagement with services and lack of cultural sensitivity have left many South Asian women in vulnerable situations and impacted negatively on their mental health. We hope this report has given voice to their experiences.

Section Five: Recommendation

5.1

Our recommendations are based on the data from our research and outline what community members of North West Kent would like for the future and are linked with the DRE action plan points set in 2000. Point 1.32 page 19 sets out the vision of the DRE that would apply

'A more balanced range of effective therapies such as peer support services, psychotherapeutic and counseling treatments... that are culturally appropriate and effective.'

Questionnaires were our main tool of data collection with 60 received back. One of our questions was based on what they (community member) would like for the future. **More qualified Asian workers within the mental health field** came as most popular option. This was also a key discussion point in the service user's forum, where all 100% agreed that they want Culture specific trained counsellors 'who truly care NOT who work for money'. 'Professional' and 'qualified', were terms used frequently since many feel there may be Asian workers in their community but 'very few care'. The need for specifically Asian workers is due to obvious things such as language and cultural understanding. One 50 + participant felt resentful of support services available in the community, since

'They [services] encourage freedom and break up homes.'

Services do not understand 'their' culture and therefore conflict arises. 95% of participants agreed there was a language barrier in accessing aid and that a lack of understanding within services therefore something clearly needs to be done. As the DRE (delivering race equality) action plan already states on point 3.62

'Providers and commissioners should also make sure that there are culturally and linguistically appropriate independent advocacy services, if necessary using strategies such as joint commissioning to ensure adequate investment and coverage.' (Page 49)

Recommendation One

Our recommendation therefore is to have a trained counsellor available to the community, on a trial period. We feel what is required is that this trained, qualified and appropriate language counsellor should be bi-lingual and have an understanding of the culture. Rethink – Sahayak is a service most people recognise, one of the few BME specific services that people know the name of and has now been established for over 10 years. The service is based in Gravesend high street therefore its location also means it is accessible. We would therefore recommend that the counsellor be funded for and linked with such a service that is already established

and has many people already accessing the service and a strong volunteer team to support promotion. This should be done on a trial basis to measure the response in the community to their request being carried out and will perhaps encourage more people to come forward and talk about their problems. If the trial is a success then this should expand to not only working with the individual but ‘family counselling’, since it is important to educate the whole family to ensure there is a change in the household and to overcome any lack of communication.

5.2

This research proves that **more education and promotion on domestic violence** is necessary. People want a place to get information, a ‘one stop shop’ type of place. Kent Police have trialed this and it was a success. More initiatives such as these are important so people have a place to access information and can be signposted to places. These access points must have at least one bi-lingual individual to break down language barriers. Promotion should include a sustained and coherent strategy of (mental) health awareness to include events such as an Asian Women’s day where information points are available with different types of activities. In this kind of situation information can be passed to all about Domestic Violence and a talk on domestic violence can also take place to raise awareness. This could link up with wider initiatives such as Public Health and Health Promotions. One service provider stated their biggest problem was for people to be

“aware we are here really. But I think mainly people don’t need a service until they need it, only look up a service when they need it. Which is all very well if you can speak English, got a computer, access internet, etc., but people who don’t sometimes they don’t know where to go so the police are often the way they access us”.

The activities described would help even those who cannot speak English get some form of information about where to go when in need.

Recommendation Two:

An Asian women’s day event should be organised, where information about services is distributed and a talk on domestic violence is given, and this should form part of a rolling campaign and strategy of awareness and education. This would provide invaluable information about services they can access and if people are educated on what South Asian domestic violence organisations and ‘frontline’ services provide for the community in terms of resources and funding then they may not be viewed as ‘homewreckers’ that some participants felt they were. Stalls should be at such an event where information can be accessed. Having events in the community are less threatening and intimidating and information can be passed to everyone. Relevant charity organisations and services should be represented with bi-lingual speakers and leaflets in different languages to ensure everyone can understand their role in the community.

5.3

More translators attached to leaflets and promotional material. The majority of our participants felt this was necessary in the community. Advertising in different languages means women who cannot speak or read English can still access information and are not excluded. Pictorial information can also be useful. This can also be linked with lack of understanding on immigration issues since more information needs to be published for people to know they are not alone in such a scenario. Between 80 and 90% participants agreed that misunderstanding the immigration process, and abuse of this process to hold power over another is a problem in society.

Recommendation Three:

A clearer perception of the issues surrounding immigration law and what implications are for individuals in such a situation needs to be highlighted in an accessible format, such as a leaflet. People need to be aware of where they can go in such a situation. Promotion could be available on this and posted in places of worship and in public toilets would be a good access point so people do not feel self-conscious of stopping and looking at information. In general the recommendation is for more publicity to be available in different languages and formats to make the community aware of services available for them.

5.4

All service providers we interacted with expressed a lack of cultural understanding; the main critique from the community was not being heard therefore this gap needs to be bridged. The best way is for training and a training pack to be developed, for service providers to understand the cultural issues. GPs were rated by a large amount of our participants as their first port of call and this was due to confidentiality however, there were still indications of not being understood. GPs would be a key sector in creating awareness and encouraging signposting. As stated by one service provider,

“it’s always a struggle with GPs, trying to get through to GPs and tell them about our services. Because they have so much on, some GPs are really good but some...(sighs)”.

If GPs have become the first service people go to, anti-depressants shouldn’t be prescribed until they have spoken to someone about their issues, all providers must become aware of common factors where women are depressed and this has been brought forward before that the local cultural capability frameworks should complement the 10 essential capabilities for mental health practice launched in 2004 by the Department of Health. *‘These capabilities, which strike a balance between value-based practice and evidence –based practice’* (DRE pt 3.37)

Recommendation Four:

A centralised information/education resource such as a diversity toolkit should be available to Service Providers and frontline practitioners such as GP's. This toolkit should outline key issues around cultural awareness and highlight the issues affecting black and minority ethnic communities, enabling practitioners and services to measure themselves against a benchmark of cultural competence. This links with DRE pt 3.35

'Within mental health trusts and PCT's , professional bodies and governance structures should plan and manage individuals' personal progress towards cultural capability , for example through appraisal and continuing professional development'.

Social service models should be created in a culturally competent manner in order to deliver high quality services that are accessible and for practitioners; cultural competence allows them to have a deeper understanding of the socio-cultural background of the women they serve.

Following on from this, a harmonised standard of diversity training should be introduced, certainly for frontline practitioners such as GP's and Counsellors. Admittedly, given the mosaic nature of many care services in the statutory, independent/voluntary and private sectors this may be a complicated task.

5.5

Service User involvement is now a key concept in health and social care services since the rise of consumerism in the late 20th century, the ideology of 'customer is always right' came to the forefront and deliverance of service was in focus. This should be applied to any kind of service and NHS is no different, 'service' is a synonym for help and one can only help when they listen to what the individual needs. In England and Wales the involvement of patients is central to current efforts to improve the quality of health care. Underlying these changes is the belief that involving patients leads to more accessible and acceptable services and improves the health and quality of life of patients. This view is endorsed by government policy, which states that involving patients leads to *"more responsive services and better outcomes of care."*(Department of health).

Linking to this concept of Service User involvement, our research showed that 23% of participants would like help from others in same position.

Recommendation Five:

Peer support and Peer (general) advocacy services, this would be a culturally competent strategy since a sense of community will still be with victim and will address cultural barriers of social isolation. Peer advocates, whether they are staff or volunteers can connect victims of domestic violence with resources that are useful and can overcome language barriers and cultural factors that prevent South Asian women from accessing services. A Peer advocate would be a trained volunteer or staff person and the Peer support person could be a previous victim and now a

survivor. Immigrant women who face Domestic Violence are caught between their culture and new mainstream culture and institutions. A Peer Advocate would help a women simplify the process and the aspect that this would be in their own language will give the individual a sense of community and safety. This Peer involvement model is recommended as a means of improving the quality of services. This links with 'South Asian Women's organizations' (Abraham, 2000) findings in their USA based population study where they found a need for more peer support groups.

5.6

While we are focused on victims of Domestic Violence who are suffering presently we must also ensure the upcoming generation are educated and are aware of the resources available to them if in the future they were in such a situation then they would be equipped to use the services around them and know there is a support system available to help.

Recommendation Six:

Concentration on the youth and assemble them to educate their generation in preventing violence, this must be in an appealing manner. Arts, plays, film series or magazines would help evoke debate and understand what the boys and girls who are South Asian and battling with cultural issues of honour/shame and gender inequality feel. This can be done but is dependent on funding and/or a committed volunteer team. Alternatively in the simplistic form, the South Asian youth of NorthWest Kent must know about this research and the results found, so they are aware of what is happening around them and that efforts are being made to improve services.

RECOMMENDATIONS AT-A-GLANCE

5.7

- We recommend funding for a trained and accredited bi-lingual counsellor on a trial basis within Rethink – Sahayak, which is one of the few recognised BME organizations within North West Kent.
- More promotion and education on Domestic Violence in format of an Asian Women's day.
- A clearer perception of the issues surrounding immigration law and what implications are for individuals in such a situation needs to be highlighted in an accessible format.
- A centralised information/education resource such as a diversity toolkit should be available to Service Providers and frontline practitioners such as GP's.
- Peer support and Peer (general) advocacy services
- Social events such as plays, films or magazines for British South Asian youth to educate and prevent future generation from being part of Domestic Violence.

Section Six: Further Investigation

As in the case of most research more areas tend to be uncovered for further research and analysis. Our aim was to investigate domestic violence and also mental illness and immigration. We feel that we were able to highlight most of what we had hoped and strong data has been found which fulfils our aims. However immigration issues need more detailed research, we found many did not understand how immigration related issues had any links with domestic violence but through service provider questionnaires and interviews the problem was boldly highlighted:

West Sussex County Council: Domestic Violence case worker,

“Immigration status can effect whether or not they access services. They are told, if they reach out, it could lead to deportation”.

West Sussex County Council: Ethnic minority information officer

Immigration issues for Asian women are

‘...like a sword hanging on your head and once married it is difficult to break and live independently’. Some women do not have friends and relatives and can’t return to their parents back home. All service providers are obliged by the law to provide the services to clients without immigration restrictions. Therefore ambiguous immigration status is an issue, particularly in DV situations.’

Several other examples have been provided (see results – Interview 1) showing what a huge issue this is so perhaps more research into immigration law and the affects it has on BME communities. It may be useful to have research with interviewees and specific case studies. However, since the community can be close knit and doesn’t like to take such steps alone a focus group could be formed to discuss such issues on immigration and services available.

Other issues we found that could be explored further in immigration are the men’s point of view and their issues surrounding immigration; this was highlighted to us in the service user’s forum, one man stated,

‘A man comes from India and has to dance to father-in-laws requests or else you’ll be packed back to India’.

This shows that immigration problems are also applicable to men from India, further investigation could look into their issues and mental health needs.

Further investigation could be done into other forms of domestic violence; we focused on women and what they face within their homes. Elderly domestic abuse is a large problem since many are neglected and dominated by their children. This is mainly due to the extended family framework that can make it difficult for them to have any authority in their own homes. We focused on daughter-in-law's lack of power in their home and suppression in the current research however; the reverse is also present in the community. Men also do face domestic abuse but due to society's opinions and stereotypes they find it difficult to come forward, perhaps more could be looked at in more detail. Alcohol abuse was also highlighted as over 70% agreed this was a big problem in most Asian households and a factor in domestic abuse. One male individual in the service user's forum stated,

"Women keep on giving headache and telling us what is going on in house after hard days work, this nagging, makes us frustrated and she doesn't understand, that's why we drink! What else will a man do?"

This highlights a major mental health issue; many of these men feel suppressed and depressed and also don't want to reach out to services since they feel that services are partial to women.

"A man has no standing in this country, all a woman has to do is go cry and a restraining order is put on you, what can we do? Who listens to our word, when is a woman restrained! We are blamed for everything. The law in this country is for women and children."

A lot more research needs to be done from the male perspective since much blame is attributed to them. But men also have cultural restraints and are brought up in a way that leads them to expect certain things from a marriage and are disorientated when expectations fall short,

'Cultural values that we have been taught, in India these values work since it's embedded in the environment that you grow up. We are told that men are in control. Coming into a western environment creates a 'cultural problem' and this causes tension and communication, adjustment problems.'

We had originally had wanted to access all Asian women, Thai and Phillipian women, but we were unable to link with organizations that focus on their needs and time constraints meant we have not interacted with any women beyond South of Asia, however research in Domestic Violence has shown immigration, cultural

expectations and gender inequalities do exist for Asian women therefore further investigation into their needs would be informative.

The main areas for further investigation have been highlighted by our research and these are immigration issues and South Asian men's mental health needs.

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Appendix

Quotes from service providers

West Sussex County Council: DV case worker

Description of organisation:

> Provides victims with options support practically and emotionally, raises awareness among agencies.

> supports 80 per annum

> Scale of problem among Asian women – BIG problem that is very under reported to both police and outside agencies.

Stats from June 2004 – Nov 2005, Crawley Horsham and Mid Sussex >

65% white British

20% Ethnic minorities

15% Don't know

> have found difficulties reaching out to Asian women.

> When Asian women have accessed services they sometimes have friends or family with them which can be hard with regards to confidentiality.

> Sometimes cultural barriers with Asian women, i.e. women thinking its ok being raped within marriage.

> Asian women spend majority of their time at home, therefore have no access to advertisements.

> Language barriers

> Lack of knowledge

> Immigration status can effect whether or not they access services. They are told, if they reach out, it could lead to deportation.

Case studies

➤ Four clients have been on two year visa.

➤ Three are still working and in the country

➤ One has made an application to the home office for indefinite leave and awaiting response

➤ One has had problems with immigration as she had indefinite leave, but her children didn't.

Dealing with Mental Health and Domestic Violence in Asian community:-

There is a BME representative present at the community drop in – particularly to help with language barriers. There is a Mental Health helpline and crisis resolution at Crawley hospital.

'There is more needed to support women from BME groups and make sure that they are aware of services available. A service for women with mental health issues would be gladly welcomed in the North Downs'.

RAVI REFUGE – Manager and Domestic violence support officer.

Organisation description:

They provide safe temporary accommodation, helping with legal matters, Rehousing women and children with housing applications. They help with state benefits, registering with local GP and the schools.

They support six individuals in a house at a time.

‘Scale of problem is much higher for Non-UK born Asian women. Education and western media help UK born Asian women.’

Ravi Refuge is culturally appropriate as staff are bi-lingual and understand the culture.

Gaps in services for BME > reliant on housing benefit therefore lack of funds. Single women are not helped and biggest issue is IMMIGRATION, takes years to go through law process.

Difficulty reaching out to Asian women > cannot help those who have no access to public funds. Those with no indefinite stay fear deportation. Family shame and dishonour large part of lack of outreach.

Biggest barriers > Language and immigration status. Cultural needs not being met – ‘an Asian woman in a white refuge is lost.’ Being let down by legal system and agencies is also a barrier.

Immigration case study

Turkish Lady has five year asylum seeker in UK yet had no resource to public funds. After one year in a refuge she had no rehousing fund therefore had to leave. The judge was forced to provide housing due to her having children. However she was eventually evicted due to no housing benefit.

West Sussex County Council : Ethnic minority information officer.

Organisation description:

Information services to BME in their first spoken language.

Help and support to access appropriate services.

Liaising, help with written and verbal communication. General advice, counselling, professional support.

The numbers of Domestic Violence cases vary approximately 10 women contact ethnic minority helpline for help. 12% is BME population, Indian, Sikh and Pakistani make up 70% of total BME population.

‘We only see the tip of the iceberg; Domestic Violence is across all sections of ethnic minority groups. Generally speaking traditionally South Asian cultures are male dominated; women suffer in silence and would always try to hide the reality. It is **not**

restricted to younger generation it also affects the older members in the communities.'

Scale of the problem? Difficult to measure Domestic Violence because physical abuse is only recognized. Members within the different communities, though limited, do have an understanding of other forms of abuse e.g. verbal, sexual etc. Lack of confidence, power and ability to come forward and report these cases is big barrier.

Gaps in services?

lack of appropriate refuge centre in Crawley and lack of appropriate women staff in statutory agencies. Language major barrier, easy and affordable access to ethnically sensitive community legal services. Liaison with local police – training of staff to deal with Domestic Violence issues.

IMMIGRATION

'...like a sword hanging on your head and once married it is difficult to break and live independently'. Some women do not have friends and relatives and can't return to their parents back home. All service providers are obliged by the law to provide the services to clients without immigration restrictions. Therefore ambiguous immigration status is an issue, particularly in Domestic Violence situations.

Immigration status specific case > have dealt with clients who were given two years of leave to stay in the country on marriage grounds. These women were facing Domestic Violence and it was difficult for them to access the services or to make up their own mind – **'no alternative but to suffer in silence till their immigration status is cleared'**.

Financial constraints make situation difficult. BME leaders should step forward and try to develop the services in partnership with local authorities. The voluntary sector can play a vital role as well.

Bangladeshi Women's group – organiser

Organisation description

Role is to raise awareness of services available.

12 people supported per annum.

Majority of women suffer in silence. The services provided are culturally appropriate since it is a safe environment and all issues are respected.

GAPS > need for more groups made available to BME Women which appeals to educate them and get them out for social and educational purposes.

Biggest barriers> men and cultural issues.

Future strategies > organising conference to highlight issues of forced marriage – Domestic Violence and mental illness.

Forum with 50+ participants

Limitation >A lack of age 50+ participants in our study was felt; therefore we accessed a service users forum. They were hesitant to fill out questionnaires, since they were taught 'personal things should stay personal', but a debate was started. Please find below extracts and opinions found...

Participants

Between 20 and 25 mixed male and female service users group. All 50 + in age and were Punjabi speaking. All were or had been married, one lady divorced. Majority were in-laws now.

Design

They did not allow for conversation/debate to be recorded in any other way other than on paper. The key points have been noted by a researcher. All identities are to remain 100% confidential. Researchers were bi-lingual therefore questions were asked in Punjabi and extract below is a translation of the thoughts expressed. The discussion lasted for approximately 40 minutes.

Discussion

The opening statement by the researcher was a question to the group, '**What is domestic violence?**'

ALL agreed that physical, verbal, emotional abuse is domestic abuse.

With explanation economic and immigration was also understood to be a 'form' of abuse. However issues such as 'sexual abuse' could not be brought up since women did not feel comfortable talking of such things in front of men, showing very old fashioned value and extreme embarrassment and discomfort around even the thought of it.

Views that were expressed...

Female answer: 'Men can treat women how they want, beat us shout at us but we will tolerate...because we are women.'

Male answer: 'Women keep on giving headache and telling us what is going on in house after hard days work, this nagging, makes us frustrated and she doesn't understand, that's why we drink!. What else will a man do?'

Above shows Men's opinion on alcohol abuse and demonstrates how they see alcohol as escape.

Why does Domestic Violence exist?

Male answer: 'Cultural values that we have been taught, in India these values work since it's embedded in the environment that you grow up. We are told that men are in control. Coming into a western environment creates a 'cultural problem' and this causes tension and communication, adjustment problems.'

Men believed problem not as big in Indian due to above statement – Women opposed.

Female answer: 'You cannot say that, it is different there and different coming and living here. Men feel sorry for themselves but WE look after children, relatives, their mothers, we are here only then they survive but we get no support. In India everybody is the same but here no support'.

Male answer: 'A man has no standing in this country, all a woman has to do is go cry and a restraining order is put on you, what can we do?, who listens to our word, when is a woman restrained! We are blamed for everything. The law in this country is for women and children'.

All men agreed with the above statement. The conversation then steered to the current generation...

'Today's' generation don't know how easy they have got it, we worked hard and they know how to spend hard!' a male voiced.

A conversation on money then followed; 'everyone is running after money'. 'Where there is love there is no money', this then went onto how finance can play a large role in causing domestic violence. 'We men earn money and these ladies spend it how they want', men felt nothing more should be expected of them. In retort one lady raised, 'that is not a favour to us, we raise your children and look after your home and are good wives'.

A power struggle is present through this exchange, who is more hard done by? The idea of a partnership or team-work is not present.

Services

Men are resentful of support services available in community, since they 'encourage freedom' and break up of homes. They do not understand 'their' culture and therefore conflict arises.

Women felt strongly about services, one lady stated "when we turned to Temple and asked them to help my daughters marriage they told us, we can't decided anything, you must talk to your daughter".

They were still isolated; this fear translates in talking to an organization since they worry it will cause further problems as opposed to help the situation.

Mental health

All agreed that stress has been felt by them, headaches and weakness were symptoms universally described. They all had an understanding of depression but many felt that they could not talk to anyone, why? 'How would it help, we have to deal with it, talking doesn't solve anything' was the only opinion stated by an angry 60 year old lady, no one else gave their opinion on this matter

Being in-laws

One 65 year old gentlemen stated, " we are hypocrites, we want our girls to rule when they get married and go their new homes and not totally trust their in-laws yet fight those girls that come into our homes with same attitude".

A woman who was a mother-in-law stated, "Mothers want their sons to themselves since their husbands were never theirs, always were their mothers".

The above statement showed mothers feel threatened by a new women entering into their home, since the son who was only theirs, will not be split in attention and emotion. This resentfulness could be seen as the reason behind the mistreatment daughter-in-laws feel.

One lady spoke of how a daughter is no longer yours once she leaves the house, "My daughter rang me to ask me advice on a house matter, I told her sternly, don't ever ask me again, you have a mother-in-law now, you consult her, and she is your support now. If you want peace in in-laws house, you got to go by their advice" Everyone's reaction in the room was really positive to that response saying it was a 'mature' way to handle things.

Other discussion points

There was a discussion that this is NOT just a women's problem, men also suffer but it is an undercover issue. 'A man comes from India and has to dance to father-in-laws requests or else you'll be packed back to India'. Immigration is highlighted as an issue for men and women something that needs to be further explored.

For the future

100% agreed that they want Indian trained counsellors 'who truly care NOT who work for money'.

More education and training is needed. Only by speaking about problems will something come out of it, therefore necessary to have counsellors.

Underlying issue of this age group

Many participants were in-laws therefore issues were seen from their perspective so therefore marriage and Domestic Violence is not a current issue in many households but daughters-in-law or sons-in-law are the issues they have to deal with. Finance

was a BIG issue and the lack of control in homes. Many were reluctant to speak and kept veering away from discussion points on money and children misbehaving. It was difficult capturing this debate and doing justice to the thoughts expressed since certain overpowering views suppressed others into not speaking. Also not being able to tape record meant much content has been lost and this is a translated piece so the true essence of what they were saying may not come across accurately, we have tried our best to bring forward their thoughts in the manner expressed at the time.

Rethink Sahayak Community Engagement Research Project

This research questionnaire is part of a Community Engagement Project conducted by Rethink Sahayak, funded and supported by the National Institute of Mental Health in England (NIMHE) and the University of Lancashire (UCLAN).

The project is part of the Black & Minority Ethnic (BME) Community Engagement programme.

Rethink Sahayak

Rethink Sahayak is a registered charity that provides community based mental health support services to the Asian community in North West Kent. Sahayak has been established for nearly 10 years.

Aims of this Project & Questionnaire

The purpose of this questionnaire and project is to investigate the experience of Asian women in North West Kent who suffer in domestic abuse situations and to try to explore any links between domestic abuse, mental illness and undetermined immigration status. The research will take into consideration race, culture and religion when considering these issues.

We anticipate that the final outcomes of this research will inform and bring about improvements in the services BME communities receive.

Consent form

Registered Charity No. 271028

CONSENT FORM

This study is being conducted by Rethink – Sahayak and is about domestic violence within the Asian community.

The aim of **Rethink Sahayak** is to gain a better understanding of the situation in Kent for domestic violence within the Asian community. A report on the findings will be used to inform policy and also to lobby for the services that YOU tell us you need.

Please READ the declaration below and SIGN, or MARK in the space provided. Please ask the researcher to read the declaration and explain it to you if you wish.

I have been requested to participate in this study and voluntarily accept.

I understand:

The aims of the research and I have been free to ask any questions.

My participation is entirely voluntary and I can withdraw at any time.

I do NOT have to answer any questions if I wish not to, but I am encouraged to answer where I can.

Any comments that I make will not be attributed to me unless I give consent.

All the information provided will be in **confidence** and it will only be shared amongst those working on the research, EXCEPT if I disclose information which reveals harms to others or child abuse – *(This will be dealt with in accordance to Rethink Sahayak disclosure procedure)*

**I confirm I have read and understood this information sheet.
I agree to take part in the domestic abuse project for Asian women.**

Signed or Marked : _____

Date : _____

Appendix 7 – Main questionnaire

Please complete the following either by a tick, rank, or write as appropriate.

PERSONAL

1) Age:

16 – 18 19 – 21 22 – 24 25 – 29

30 – 39 40 – 49 50 +

2) Gender:

Male Female

3a) Ethnicity: Asian or Asian British

Punjabi Indian Gujrati

Bangladeshi Pakistani Other (specify) _____

3b) What is your religion?

None Christian Buddhist Hindu

Jewish Muslim Sikh

Other (Specify) _____

4) What is your sexuality?

Lesbian or gay woman Homosexual or gay man Bisexual

Heterosexual or straight Transgender or transsexual

5a) Marital Status:

Single Married/Cohabiting Divorced

Separated Widowed Other
(specify) _____

4b) If Married, what type of marriage did you have?

Love Arranged Assisted Forced

Other _____

4c) If you are still Married, how long have you been married?

Less than 1 year 1 – 5 years 6 – 10 years

11 –15 16 –20 years 21 – 25 years

25+

4d) If you are divorced, how long was you married for?

5) No. of children if any?

0 1 – 2 2 – 3

3 – 4 5 +

6) Who do you live with?

Own home (nuclear family) With parents

With extended family (in-laws) Flatmates

Partner Single parent

Other _____

6a) Were you born in the UK?

Yes No

6b) If No, how long have you lived in the UK?

Less than 1 year 1 – 5 years 6 – 10 years

11 +

7) Citizenship/Status

Naturalised /British Refugee /Indefinite leave to remain

Humanitarian Protection Asylum Seeker Extended leave to Remain

Discretionary leave Awaiting appeal No Status Granted

Other _____

8) What is your current employment status?

Full- time Part – time Unemployed Receive Benefits

Student Housewife Other _____

9) Which language(s) do you speak?

Language	Spoken	Written
-----------------	---------------	----------------

English	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Punjabi	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Hindi	<input type="checkbox"/>	<input type="checkbox"/>
-------	--------------------------	--------------------------

Urdu	<input type="checkbox"/>	<input type="checkbox"/>
------	--------------------------	--------------------------

Gujrati	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Bangali	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Other _____		
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10) Do you have a disability? Yes/No

If yes, please state _____

AWARENESS

10a) Do you believe that domestic abuse exists within the Asian community in the UK?

Yes No (If No, go to question 11)

10b) Do you agree with the following statement, “Domestic abuse is a big problem in most Asian households” (Please circle on the scale below)

Strongly Disagree

Strongly Agree



11) What do you associate with Domestic Abuse? (Please tick all that apply)

- Physical Abuse
- Emotional Abuse
- Verbal Abuse
- Sexual Abuse
- Economic Abuse
- Alcohol Abuse
- Drugs Abuse
- Immigration Status
- Keeping children away
- Family pressure
- Other Please state _____

12a) Do you think that domestic abuse is culturally accepted within your Asian community?

Yes No Not sure

12b) Do you think there is “shame/dishonour” attached to getting support for domestic abuse within the Asian Community?

Yes No Don't know

12c) If Yes, why do you believe this?

13) Have you experienced Domestic Abuse personally? (If No go to question 15)

Yes No Not sure

13b) How long has it been happening?

1-3 months 4-6 months 6-12 months

1-2 years 3-4 years 5years +

14a) Did the impact of the situation cause you to do any of the following?

Consult your Doctor (GP)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stay in a Hospital	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Take time off work	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Difficulty eating, sleeping	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not sure <input type="checkbox"/>
Feel worried, anxious, stressed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not sure <input type="checkbox"/>
Lose self-confidence	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not sure <input type="checkbox"/>
Feel depressed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not sure <input type="checkbox"/>
Feel scared, fearful	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not sure <input type="checkbox"/>

14b) Have you experienced any of the following? (Please tick all that apply)

Depression	<input type="checkbox"/>
Guilt	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>
Suicide attempts	<input type="checkbox"/>
Headaches/ Migraine	<input type="checkbox"/>
Intrusive thoughts	<input type="checkbox"/>
Flashbacks	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>
Difficulties sleeping	<input type="checkbox"/>
Emotional numbness/withdrawal	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>
Drinking too much alcohol or taking drugs	<input type="checkbox"/>
Relationship difficulties	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>
Aches	<input type="checkbox"/>
Pain:	
Emotional	<input type="checkbox"/>
Physical	<input type="checkbox"/>

17d) Were you happy with the support/treatment you were provided with, did you find it helpful?

Yes No

Why?

18) What kind of help would you have liked with your mental health problems?

- Support of relatives and friends
- Medication
- Counselling
- Therapy
- Information
- Spiritual support
- Drop-ins
- Help from others in the same position
- General practitioner
- Befriending
- Hospital
- Support worker
- Other (please specify) _____

Immigration status: (answer true or false to the following statements)

19a) Not having a permanent UK Immigration status can affect domestic abuse situations.

True False Don't know

19b) Non-UK residents are threatened with deportation when in a domestic abuse situation.

True False Don't know

20a) If Non-UK resident or born in another country what events have you experienced in your home country or during your journey to the UK?

- War
- Torture
- Violence
- Destruction of your home
- Sexual assault
- Rape
- Domestic violence
- Separation from family or friends
- Lived in refugee camp
- Detention/imprisonment
- Serious illness
- Financial problems
- Isolation
- Other (please specify) _____

20b) What events have you experienced in the UK?

- Detention
- Homelessness
- Family problems
- Poverty
- Separation from family /friends
- Violence
- Racial abuse
- Unemployment
- Uncertainty about your legal status
- Social isolation
- Racism and discrimination
- Language difficulties
- Sexual assault
- Rape
- Domestic violence
- Serious illness

Financial problems
Other (Please specify) _____

21) Within the Asian community Alcohol abuse plays a large role in the onset of Domestic Abuse. Do you agree? (mark your answer on the scale below)

Strongly Disagree

Strongly Agree

1 2 3 4 5
^ _____ ^ _____ ^ _____ ^ _____ ^ _____
_____ ^

22) Please state out of the options given who is MOST and LEAST responsible for causing domestic abuse

Husband
Wife
Father
Mother
Father-in-law
Mother-in-law
Children
Other relative (*Please specify*)

MOST _____

LEAST _____

INFORMATION SERVICES

23) “There are many services available for ASIAN WOMEN in domestic abuse situations within your area”. Do you agree? (Mark your answer on the scale below)

Strongly Disagree

Strongly Agree



24a) If someone in the Asian community had a domestic abuse problem, who do you think they would approach for advice/help? (Rank the top 5 most approachable.

1 = most approachable)

- Telephone Helpline
- Work Colleague
- Family member
- Community Worker
- Police
- Doctor
- Religious Leader
- Refuge Shelter
- Internet
- Psychologist
- Family
- Friend
- Other Please state _____

24b) What makes rank 1 most approachable?

25a) Are you aware of any services that specifically help Asian women suffering from domestic abuse?

Yes No Not sure

25b) If Yes, please state?

26a) Have you ever been refused from using a service when seeking support for a domestic abuse situation?

Yes No

26b) If Yes, why and when?

27) Do you feel that there are language problems when accessing aid for domestic abuse for those whose first language isn't English?

Yes No Don't know

29) In your opinion which 3 would be most useful for the Asian community? (Please tick the 3 you feel would be most useful)

- Information leaflets in other languages (Punjabi/Hindi/Urdu...)
- Domestic abuse awareness promotions
- Education into how Domestic Abuse can lead Mental illnesses
- Support group
- A translator attached to all local domestic abuse aid
- More qualified Asian workers
- Other

If Other, please state _____

Debrief sheet

Registered Charity No. 271028

Debrief Sheet

Thank you for taking the time out to answer our Questionnaire. A final report will be created to present our findings. All contributors will be anonymous.

We hope to bring an improvement in BME (Black Minority Ethnic) services through this research, so your time will hopefully bring a difference.

YOU are in your full rights to have your data removed at any point even after filling out questionnaire.

All data will be destroyed once accounted.

If you have any questionnaires or queries please contact one of the Researchers

Reena Sooch reena.sooch@rethink.org

Gurpreet Kalyan gurpreet.kalyan@rethink.org

Jasminder Rai jasminder.rai@rethink.org

Tel: 01474 364837

For support and information call FREEPHONE – Asian language mental healthline

Tel: 0808 800 2073 Monday and Wednesday 6.00pm – 9.00pm
Tuesday and Thursday 12.00 noon – 3.00pm

24HR National domestic violence helpline (Freephone) 0808 2000 247

Interview consent form

Registered Charity No.

271028

CONSENT FORM

This study is being conducted by Rethink – Sahayak and is about Domestic violence within the Asian community.

The aim of Rethink Sahayak is to gain a better understanding of the situation in Kent for Domestic violence within the Asian community. A report on the findings will be used to inform policy and also to lobby for the services that YOU tell us you need.

Please READ the declaration below and SIGN, or MARK in the space provided. Please ask the researcher to read the declaration and explain it to you if you wish.

I have been requested to participate in this study and voluntarily accept.

I understand:

The aims of the research and I have been free to ask any questions.

My participation is entirely voluntary and I can withdraw at any time.

I do NOT have to answer any questions if I wish not to, but I am encouraged to answer where I can.

Any comments that I make will not be attributed to me unless I give consent.

All the information provided will be in confidence and it will only be shared amongst those working on the research, EXCEPT if I disclose information which reveals harms to others or child abuse – *(This will be dealt with in accordance to Rethink Sahayak disclosure procedure)*

I understand that the audio recording of this interview will be destroyed once the tape has been transcribed

- I confirm I have read and understood this information sheet.
I agree to take part in the domestic abuse project for Asian women.

Signed or Marked : _____

Date : _____

Appendix 10 – Personal data collection and TEMPLATE for interview

Please complete the following either by a tick, rank, or write as appropriate.

PERSONAL

1) Age:

16 – 18

19 – 21

22 – 24

25 – 29

30 – 39

40 – 49

50 +

2) Gender:

Male

Female

3a) Ethnicity: Asian or Asian British

Punjabi

Indian

Gujrati

Bangladeshi

Pakistani

Other (specify) _____

3b) What is your religion?

None

Christian

Buddhist

Hindu

Jewish

Muslim

Sikh

Other (Specify) _____

4) What is your sexuality?

Lesbian or gay woman

Homosexual or gay man

Bisexual

Heterosexual or straight

Transgender or transsexual

5a) Marital Status:

Single

Married/Cohabiting

Divorced

Separated Widowed Other
(specify) _____

4b) If Married, what type of marriage did you have?

Love Arranged Assisted Forced

Other _____

4c) If you are still Married, how long have you been married?

Less than 1 year 1 – 5 years 6 – 10 years

11 – 15 16 – 20 years 21 – 25 years

25+

4d) If you are divorced, how long was you married for?

5) No. of children if any?

0 1 – 2 2 – 3

3 – 4 5 +

6) Who do you live with?

Own home (nuclear family) With parents

With extended family (in-laws) Flatmates

Partner Single parent

Other _____

6a) Were you born in the UK?

Yes No

6b) If No, how long have you lived in the UK?

Less than 1 year 1 – 5 years 6 – 10 years

11 +

7) Citizenship/Status

Naturalised /British Refugee /Indefinite leave to remain

Humanitarian Protection Asylum Seeker Extended leave to Remain

Discretionary leave Awaiting appeal No Status Granted

Other _____

8) What is your current employment status?

Full- time Part – time Unemployed Receive Benefits

Student Housewife Other _____

9) Which language(s) do you speak?

Language	Spoken	Written
-----------------	---------------	----------------

English	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Punjabi	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Hindi	<input type="checkbox"/>	<input type="checkbox"/>
-------	--------------------------	--------------------------

Urdu	<input type="checkbox"/>	<input type="checkbox"/>
------	--------------------------	--------------------------

Gujrati	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Bangali	<input type="checkbox"/>	<input type="checkbox"/>
---------	--------------------------	--------------------------

Other _____		
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10) Do you have a disability? Yes/No

If yes, please state _____

Date:

Interview No. :

NOTE: Interviewer would tick points as they were mentioned by the participant, if the particular point has not be raised the interviewer would bring point in to discuss.

Template for SEMI structured Interview: Points to be discussed.

So start from the beginning, family background... (Liberal or conservative)

- Were you born in the UK? *(If NO then ask immigration questions below)*
- Are you married, divorced? If yes... If no, last relationship?
- What age did your marriage take place?
- Was is choice or forced?
- Was the guy from UK? – YES/NO – effects of this...

Description of husband/partner...

- Do you understand one another?
- Relationship with in-laws
- Adjustments into a new home

How was their marriage...?

- Any change in husband at any point, or same individual from day one
- Family support in marriage
- Children?

What is domestic abuse in your opinion?

What was the first incident? - Mental or physical

- How long has it happened/happening
- Effect on mental well being – symptoms – anxiety, depression, withdrawal etc.
- Who did you tell? – reaction
- Was any help offered from family or outside
- Was their a change in your personality
- Did culture have an impact on your mental health? – idea of honour (izzat)
- Community's attitude important?

Did you seek help from any services?

- Where? When?
- What support was offered?
- Did u take the support? Was this helpful
- Was accessing help easy?

- Did you know the options available to you in the community?

If did NOT seek help

- Why?
- Were you aware you could seek help?
- Did family offer support? – were they aware
- How did you deal with the Domestic abuse?

Immigration

- Was your Non-permanent status used against you?
- Do you feel being a Non UK resident made your situation worse?
- Did you try to seek help? When and Where? – was it more difficult

Current position

- Where are they now? – With family, in a refuge, or independent.
- Pressure on mental health?
- What would have made things easier for you? – in retrospect
- What would you advise to someone in a similar situation?
- Overview – Happy where they are? Family's standing? - Situation as it stands.

271028

Debrief for interviewee

Thank you for taking the time out to be interviewed.

This research interview is part of a Community Engagement Project conducted by Rethink Sahayak, funded and supported by the National Institute of Mental Health in England (NIMHE) and the University of Lancashire (UCLAN).

The project is part of the Black & Minority Ethnic (BME) Community Engagement programme.

Rethink Sahayak

Rethink Sahayak is a registered charity that provides community based mental health support services to the Asian community in North West Kent. Sahayak has been established for nearly 10 years.

Aims of this Project & Interview – Case study

The purpose of this interview and project is to investigate the experience of Asian women in North West Kent who suffer in domestic abuse situations and to try to explore any links between domestic abuse, mental illness and undetermined immigration status. The research will take into consideration race, culture and religion when considering these issues.

We anticipate that the final outcomes of this research will inform and bring about improvements in the services BME communities receive.

A final report will be created to present our findings. All contributors will be anonymous.

Reminder:

YOU are in your full rights to have your data removed at any point even after transcription of your interview.

All data will be destroyed once accounted.

If you have any questionnaires or queries please contact one of the Researchers

Reena Sooch
Gurpreet Kalyan
Jasminder Rai

reena.sooch@rethink.org
gurpreet.kalian@rethink.org
jasminder.rai@rethink.org

Tel: 01474 364837

Service provider questionnaire

SERVICE PROVIDERS

Name of ORGANISATION:

Date:

Designation/role within Organisation:

Geographical area covered:

What is the nature of your work/ what services do you provide? (Brief overview)

Please complete the following by tick; you do not need to answer all questions if you wish not to. Thank you.

PERSONAL

1) Age:

16 – 18 19 – 21 22 – 24 25 – 29
30 – 39 40 – 49 50 +

2) Gender:

Male Female

3a) Ethnicity:

White British
 Irish
 Other (write in) _____

Mixed White and Black Caribbean
 White and Black African
 White and Asian
 Other (write in) _____

Asian or Asian British Indian
 Pakistani
 Bangladeshi
 Other (write in) _____

Black or Black British Caribbean
 African
 Other (write in) _____

Chinese or other ethnic group
 Chinese
 Other (write in) _____

3b) What is your religion?

None Christian Buddhist Hindu

Jewish Muslim Sikh

Other (Specify) _____

4) What is your sexuality?

Lesbian or gay woman

Homosexual or gay man

Bisexual

Heterosexual or straight

Transgender or transsexual

5) Which language(s) are you fluent in?

Language	Spoken	Written
English	<input type="checkbox"/>	<input type="checkbox"/>
Punjabi	<input type="checkbox"/>	<input type="checkbox"/>
Hindi	<input type="checkbox"/>	<input type="checkbox"/>
Urdu	<input type="checkbox"/>	<input type="checkbox"/>
French	<input type="checkbox"/>	<input type="checkbox"/>
Spanish	<input type="checkbox"/>	<input type="checkbox"/>

Other(s) _____

6) Do you have a disability? Yes/No

If yes, please state _____

- 1) How many people do you support per annum?

- 2) How prevalent do you think Domestic abuse is within the community you serve?

- 3) What do you think the scale of the problem is amongst Asian women particularly?

- 4) How do you record your data, particularly do you record ethnicity? Is this information available to us?

- 5) Which of your services are used most by Asian women?

- 6) Do you feel your services are culturally appropriate, if so how?

7) Could you identify any gaps relating to BME communities in your services?

8) Do you face any difficulty in reaching out to Asian women, please specify?

9) How do you think Asian women get information about services?

10) What do you think are the biggest barriers for Asian women when accessing services?

11) Do you think ambiguous Immigration status can prevent Asian women from reaching out to service providers?

11b) Have you dealt with any specific cases where the immigration status of a client has posed a problem?

12) Is there any data you could share with us which is linked with any of the above questions?

13) Does your organisation have any plans or strategies to specifically address issues Asian women face in terms of mental ill health and/or domestic abuse?

14) Any other comments?

**Working together to help everyone affected by severe mental illness
recover a better quality of life**

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company limited by guarantee.

