Safe *and* Sane

A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women

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and
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Southall Black Sisters

Diana
Princess of Wales Memorial Fund
The Work Continues

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Dedication

This report is dedicated to the memory of Professor Catherine Itzin-Borowy, former Director of the Department of Health Victims of Violence and Abuse Prevention Programme, and Professor of Mental Health Policy based at the University of Lincoln, who encouraged and supported Southall Black Sisters in obtaining funding for and writing this report.

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CONTENTS

List of Abbreviations

BME	Black and Minority Ethnic
CEDAW	Convention for the Elimination of All Forms of Discrimination Against Women
CVS	Community and Voluntary Sector
DCA	Department of Constitutional Affairs
DH	Department of Health
ECHR	European Convention on Human Rights
FGM	Female Genital Mutilation
GP	General Practitioner
HTP	Harmful Traditional Practices
NICE	National Institute for Clinical Excellence
NHS	National Health Service
PCT	Primary Care Trust
PTSD	Post Traumatic Stress Disorder
SBS	Southall Black Sisters

EXECUTIVE SUMMARY

BACKGROUND

In April 2001, Southall Black Sisters (SBS) received funding to establish a Domestic Violence and Mental Health Project for black and minority ethnic (BME) women. The Project undertook action based research aimed at developing new models of intervention to reduce the incidence of mental breakdown, suicide and self-harm amongst BME women experiencing domestic violence. This report mainly deals with the work of the Project over a period of six years, April 2001 to March 2007 with an update from April 2007 to March 2009, and therefore covers a total period of eight years from 2001 to 2009. It helps to address the gap in knowledge and action in this area and seeks to describe and evaluate the SBS model of intervention, and use this as evidence to advocate and influence social policy reform and best practice.

The Project has built upon thirty years of work with BME, particularly South Asian, women who approach SBS seeking assistance to escape domestic violence and associated problems of mental distress and illness ranging from emotional stress and depression, which are most common, to psychological and psychiatric conditions or disorders. In particular, SBS noted that most of the women who come to SBS have contemplated suicide at least once in their lives. Many have also attempted suicide and self-harm, and a few have tragically committed suicide. Over a period of thirty years, we have dealt with 18 suicides or death due to unknown causes. In virtually all cases, domestic violence had been a causal or contributory factor, rather than any diagnosed pre-existing psychiatric illness. This confirms the findings of wider research which show a disproportionately high rate of suicide, attempted suicide, suicide ideation and self-harm amongst South Asian women, particularly young women, where very few have any pre-existing history of psychiatric illness. The Department of Health (DH) has a target of reducing suicide rates by 20 per cent by the year 2010. While suicide rates have generally fallen by 20 per cent, there appears to be no evidence to suggest that this is also the case for South Asian women.

In this context, the Project sought to develop effective models of intervention which helped BME women to be both safe and sane: escape domestic violence and to prevent and overcome the trauma of abuse in order to lead independent lives free from violence and the risk of mental breakdown. Ultimately, the Project reduces economic and human costs by helping to prevent repeat victimisation and reducing suicide and mental health problems.

The Project also tackles intersectional discrimination experienced by BME women

whose needs are often rendered invisible by mainstream policies and services. These ignore equality and diversity issues or deal with either race *or* gender, rather than address both race *and* gender at the point where the needs of BME women intersect. Multicultural, social cohesion and multi-faith policies and institutionalised racism have prevented effective action against violence against BME women or treatment of their mental health problems.

THE SBS MODEL

SBS used its experience of providing effective holistic services to BME women to develop the new 'SBS Model'. The Project, initially established in 2001, to provide advice, advocacy, and support and befriending services for women with mental health needs, was extended in 2002 to include counselling and psychotherapy.

In particular, the Project assisted 3,380 women over eight years, dealing with 6,485 aspects or issues. It had a success rate of 82 per cent in a sample of 89 cases (only four per cent were unsuccessful), and 94 to 96 per cent in counselling. In a sample survey of 15 service users, there was a 93 per cent satisfaction rating with SBS services being very good to excellent. These success rates helped to reduce the incidence of or the effect of domestic violence and mental health problems, including suicide and self-harm as indicated by low repeat victimisation rate (only 1 percent in a sample of 89 women) and a greater sense of safety and well being, including lower levels of depression, suicide ideation and self-harming behaviour and reliance on medication. As a result of the high success rate in managing and preventing mental health problems related to domestic violence and abuse, this report recommends that the SBS model be replicated to target the needs of BME women in both medical and social care services.

The SBS model helps to prevent the 'medicalisation' or over-medication of BME women by recognising and eradicating or reducing the social causes, namely domestic violence and abuse, of mental illness. In fact, a DH Taskforce focus group and sub-group recommended the work of SBS as best practice, and added that, [1]

> *'it is generally accepted that advocacy/interpretation services and specialist support can be effective or, in some cases, an essential part of care provision. It is self-evident that a victim of honour based violence who is fearful and unable to communicate in English will need support to explain what has happened to her. The work of organisations, such as SBS... can play an important part in helping victims to rebuild their lives.'*

However, despite this recognition, and many other welcome recommendations in the final report of the Taskforce in March 2010,[2] we remain concerned that there will be insufficient resources and commitment to fully implement them. In addition, we do not believe the Taskforce recommendations go far enough in addressing the needs of BME women and girls.

HUMAN RIGHTS OBLIGATIONS

The UK government's human rights obligations as outlined in the Human Rights Act 1998 and international conventions and declarations, including the Beijing Declaration and Platform for Action 1995,

the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) 1979 and the Convention on the Rights of the Child 1989 must be carried out with due diligence[3]. Indeed, in 2008, the CEDAW committee specifically stated in its concluding observations in the UK report[4] that it was concerned about the higher rates of depression amongst minority women and high rates of suicide amongst Asian women. It recommended measures to address intersectional discrimination, including the provision of more voluntary sector counselling, refuge and support services, and said there was a need for:

'...the adoption of targeted and culturally-appropriate strategies and programmes, including preventive and interventional, to address mental health issues faced by women of different ethnic and minority communities.'

However, this research shows that BME women continue to remain invisible because of their position at the intersection between race and gender where health and social care initiatives do not meet their multiple and overlapping needs, resulting in systemic failures.

SBS RECOMMENDATIONS

This report makes a number of recommendations to prevent and protect BME women from domestic violence and mental health problems within an integrated national strategy on violence against women and girls, and the human rights framework aimed at ending intersectional discrimination based on race and gender. It also promotes a secular, progressive 'mature multicultural'[5] approach in tackling violence against BME women and girls.

More specifically, the report makes ten key recommendations:

1. The SBS model, which provides holistic specialist services for abused BME women by combining advice, advocacy and support services with counselling and psychotherapy, should be fully funded and replicated in every Primary Care Trust area with a high BME population.
2. SBS counsellor, Shahrukh Husain's new 'hybrid' model of psychotherapy should be replicated and mainstreamed. The 'hybrid' model combines established humanistic, cognitive-behaviourist and psychodynamic therapies in a fluid way, allowing for some relaxation of boundaries and flexibility in communication, using when necessary, some directional elements drawn from Life Coaching.
3. The hybrid model is effective in the treatment of Post Traumatic Stress Disorder (PTSD) and so recommend domestic violence as experienced by BME women is added to the DSM-IV-TR diagnostic criteria for PTSD, either as a sub-category within the Battered Women's Syndrome (as developed by the Survivor Theory) or in a category of its own, so that the impact of religious and cultural pressures such as notions of 'shame' and 'honour,' and of racism, are taken into account. These values and experiences engender feelings of fear, shame and guilt which elevate the risk of developing PTSD.

4. Issues of domestic violence should be taken into account in suicide cases, particularly in coroners' courts, in order to prevent future fatalities. We call on the coroner's courts to accept expert evidence in court, allow third party interventions by BME women's groups and make recommendations to public bodies in order to reform policy and practice. There should also be a legal duty on public bodies to respond to the coroner's recommendations within set time limits.
5. The Government should introduce legal reform to strengthen provision on criminal liability for suicide in a new offence of homicide: 'Constructive manslaughter/suicide aggravated by harassment or violence'.
6. Minimum standards, guidance and compulsory training should be developed by the NHS and other health and social care bodies in consultation with specialist, secular BME women's organisations.
7. Immigration and asylum law, and the no recourse to public funds requirement, should be reformed so that migrant women experiencing domestic violence and other forms of gender based violence have access to benefits, housing and free NHS health services, and are granted refugee status or indefinite leave to remain in the UK to prevent a deterioration in their mental health and to keep them safe from further harm.
8. The DH should establish a cross-government Ministerial working group, which includes representation from secular BME women's organisations, to develop strategies to tackle domestic violence and mental health problems amongst BME women. One of its first tasks should be to hold a public inquiry into suicide and self-harm amongst abused BME women. It should also commission research and ensure more effective monitoring by public bodies to ascertain the scale of suicide and self-harm within BME communities.
9. Long-term preventative work should be undertaken in schools, colleges and within BME communities to raise awareness aimed at changing attitudes and behaviour and to inform BME women and girls of their rights.
10. More regular and effective inspections by the Quality Care Commission or similar body to monitor and enforce the implementation of policies and best practice which meet human rights standards, such as those required by CEDAW, within the health and social care services.

These recommendations continue to be relevant to any new bodies established by the Coalition Government, elected in May 2010. However, we are concerned that cuts in public spending and the 'Big Society' agenda may undermine the implementation of these recommendations, such as funding for specialist provision.

Full recommendations on page 112

INTRODUCTION

In April 2001, Southall Black Sisters (SBS)[1] received funding[2] to establish a Domestic Violence and Mental Health Project for black and minority ethnic (BME) women. The Project undertook action based research aimed at developing new models of intervention to reduce the incidence of mental breakdown, suicide and self-harm amongst BME women (particularly young women/girls) experiencing domestic violence (which incorporates harmful traditional practices)[3]. This report deals mainly with the work of the Project over a period of six years, April 2001 to March 2007. However, there is an update for the two-year period from April 2007 to March 2009, which is added at the end of or integrated into the relevant chapters. It also highlights some significant issues before and after the eight-year period of the Project.

THE SBS DOMESTIC VIOLENCE AND MENTAL HEALTH PROJECT

The Project has built upon 30 years of work with BME, particularly South Asian,[4] women who approach SBS seeking assistance to escape domestic violence and associated problems of mental distress and illness ranging from emotional stress and depression, which are most common, to psychological and psychiatric conditions or disorders. Most women who come to SBS have contemplated suicide at least once in their lives. Many have also attempted suicide and self-harm, and a few have tragically committed suicide. Over a period of 30 years, we have dealt with 18 suicides or death due to unknown causes. In virtually all cases, domestic violence had been a causal or contributory factor, rather than any diagnosed pre-existing psychiatric illness. This confirms the findings of wider research which show a disproportionately high rate of suicide, attempted suicide, suicide ideation and self-harm amongst South Asian women, particularly young women, where very few have any pre-existing history of psychiatric illness. Indeed, research by Raleigh et al over three decades consistently found that Asian women, particularly those aged 15-34, are up to three times more likely to kill themselves than women in the general population.[5] In the experience of SBS, these high rates are linked to additional constraining factors or barriers within and outside the community which prevent Asian women from escaping abuse, driving them to a desperate act where they feel they have no option but to kill themselves (see chapter 3 for more information). The Department of Health (DH) had a target of reducing suicide rates by 20 per cent by the year 2010. While suicide rates have generally fallen by 20 per cent,[6] there appears to be no evidence to suggest that this is also the case for South Asian women.

In this context, the SBS Project sought to develop effective models of intervention

which helped BME women to be both safe and sane: to escape domestic violence and to prevent and overcome the trauma of abuse in order to lead independent lives free from violence and the risk of mental breakdown, suicide and self-harm. Ultimately, the Project reduces economic and human costs.[7] By helping to prevent repeat victimisation and reducing suicide and mental health problems, the Project ensures that the cost of housing, supporting, policing and protecting women from domestic violence by agencies such as the police and social services is reduced. It also reduces costs to the health service in the treatment of physical and psychological injury, and benefits society by tackling crime, promoting public health and saving lives.

The Project also tackles intersectional discrimination experienced by BME women whose needs are often rendered invisible by mainstream policies and services. These either ignore equality and diversity issues or deal with either race *or* gender, rather than address both race *and* gender at the point where the needs of BME women intersect. Multicultural, social cohesion and multi-faith policies and institutionalised racism have prevented effective action against violence against BME women and hindered treatment of their mental health problems (see below for more detail).

The SBS model

SBS used its experience of providing effective holistic services to BME women subjected to domestic violence to develop the new 'SBS Model'. The Project, initially established in 2001, to provide advice, advocacy, and support and befriending services for women with mental health needs, was extended in 2002 to include counselling and psychotherapy (see chapters 1 and 2). This report seeks to describe and evaluate this model of intervention, and uses this as evidence for action based research to advocate and influence social policy reform and best practice, thus helping to address the gap in knowledge and action in relation to BME women experiencing domestic violence and mental health problems.

The Project assisted 3,380 women over eight years, dealing with 6,485 separate issues. It had a success rate of 82 per cent in a sample of 89 cases outcomes (only 4 percent were unsuccessful, and in 14 per cent of the cases the outcome was unknown or pending). Of those women who received counselling, 94 to 96 per cent were successful in overcoming trauma. Owing to time constraints, a sample of 15 of the 89 women were interviewed to assess their satisfaction with the SBS service. There was a 93 per cent satisfaction rating with services being rated from very good to excellent. These success rates helped to reduce the incidence of or the effect of domestic violence and mental health problems, including suicide and self-harm as indicated by low repeat victimisation rate (only 1 percent in a sample of 89 women) and a greater sense of safety and well being, including lower levels of depression, suicide ideation and self-harming behaviour and reliance on medication (see Evaluation section for more detail).

The SBS counselling and psychotherapy service involved the development of a new 'hybrid' model of psychotherapy, which reflected the specific

race and gender needs of BME women experiencing domestic violence. The 'hybrid' model was developed by the SBS psychotherapist, Shahrukh Husain, who used a new method of working which combined established humanistic,[8] cognitive-behaviourist[9] and psychodynamic[10] therapies in a fluid way, allowing for some relaxation of boundaries and flexibility in communication, using when necessary, some directional elements drawn from Life Coaching.[11] In particular, the hybrid model is effective in the treatment of Post Traumatic Stress Disorder (PTSD) and we recommend additions to the diagnostic criteria for PTSD so that the impact of religious and cultural pressures such as notions of 'shame' and 'honour', and of racism on abused BME women are taken into account, either as a sub-category of the Battered Women's Syndrome (as developed by the Survivor Theory)[12] or as a category of its own (see chapter 2). The Project also uniquely raises issues of domestic violence in suicide cases, particularly the lack of interrogation of domestic violence in Coroners' courts, in order to prevent future fatalities (see chapter 3), and makes other legal and policy interventions in order to influence social reform and best practice in relation to BME women, mental health and domestic violence issues, including advocating legal reform to strengthen provision for criminal liability for suicide in cases of domestic violence (see chapter 4).

The SBS model helps to prevent the 'medicalisation' or over-medication of BME women by recognising and eradicating or reducing the social causes, namely domestic violence, of their mental health problems. Often, such women have been subjected to the medical model of treatment without serious attention being paid to the circumstances in which they live. In Chapter 2, Shahrukh Husain recognises the importance of practical issues such as housing or immigration status as factors affecting women's mental health when reflecting on her own practice. Husain sometimes feels the impulse to resolve the practical matters herself and must remind herself of the boundaries of her work which is 'the strengthening of the client's inner resources'. However, Husain's reflection on boundaries reinforces the SBS view that social factors are a key determinant of women's mental health. The model therefore aims to be holistic by combining specialist social welfare intervention with counselling services which take account of disadvantage produced by intersectional discrimination based on race and gender. As a result of a high success rate, this report recommends the model be replicated in other areas to target the needs of BME women in both medical and social care services. Indeed, the DH Taskforce focus group and sub-group,[13] established in 2009, recommended the work of SBS as best practice, and added that [14]:

'it is generally accepted that advocacy/interpretation services and specialist support can be effective or, in some cases, an essential part of care provision. It is self-evident that a victim of honour based violence who is fearful and unable to communicate in English will need support to explain what has happened to her. The work of organisations, such as SBS...can play an important part in helping victims to rebuild their lives.'

(See 'Executive summary, Evaluation and recommendations' on the Evaluation of the Project and Recommendations for action.)

THE CONTEXT

The SBS model has been developed within a specific social context which impacts on BME women's experience of domestic violence and mental illness. The model aims to address the complex issues and pressures experienced by BME women within and outside minority communities as outlined below.

The BME family and community

As in the majority community, mental illness is taboo within BME communities. Mental illness carries a stigma and arouses wariness and fear in people who assume the mentally ill may become violent or that the illness itself maybe 'catchy'. The mentally ill are also isolated, treated as social outcasts, harassed, ridiculed as the 'village fool', over-medicated rather than being assisted to obtain appropriate medical treatment and social care.

Anyone acting outside the norm may be labelled 'mad'. Women with non-conformist or rebellious behaviour such as those who refuse to be obedient to their husbands and families and who challenge domestic violence or other oppressive practices, are often labelled as 'mad' rather than 'angry,' even where they have not shown signs of mental illness. Mental health agencies may collude in this interpretation of mental illness, particularly for women from South Asian and other minority communities who may be stereotyped as 'passive' or 'submissive'. By labelling rebellious women as 'mad', the family and community use the state to provide 'treatment' in order to 'cure' them, thus de-legitimising their claim for protection from abuse. This approach is often adopted in the name of cultural or religious sensitivity (see section below on state response).

There is little understanding of how BME women suffer mental health problems as a consequence of abuse which, combined with conservative attitudes and value systems which justify violence against women and are unsympathetic towards mental illness generally, prevents effective action against both of these problems.

The impact of religion and culture

Many within the family or community do little to protect women from abuse, and may even perpetrate or collude with abusive behaviour, caring little about the impact on women's health and safety. Such abuse is often justified by cultural and religious norms and values such as family honour. In some minority communities, such as the South Asian and Middle Eastern communities, the tradition of *izzat* (honour) is extremely powerful. Honour is aimed at controlling female sexuality and autonomy as the reputation of the family and even that of the wider community rests on women conforming to traditional gender roles as good and dutiful wives, sisters, mothers, daughters and daughters-in-law. Women are commonly 'punished' for bringing *sharam* (shame) to the family's honour through social ostracism, sometimes through harassment and acts of violence and, at the extreme end, murder (also known as so-called 'honour killings') and suicide. The fear of bringing dishonour and incurring such severe punishment is one of the main

reasons why women are unable to leave abusive situations.

In tight-knit and conservative minority communities, the active involvement of male elders and community leaders in maintaining the institution of the family adds to the pressures on women to return to, or stay in, violent situations at home. This can be in the form of mediation where such elders and leaders reconcile women back into the home without challenging the abusive behaviour. The growth of religious fundamentalism in all faiths or conservatism generally, particularly amongst young men, has increased pressures on BME women to conform to traditional gender roles in the family within minority communities. As a result, women's ability to escape domestic violence is being curtailed by the community in more organised ways. This has occurred in the form of increased policing by networks or gangs of men (often made up of male relatives and community members) or 'bounty hunters' to intimidate women who leave home to force them to return or harass and even kill them for bringing shame and dishonour. Cases have come to light particularly in the Midlands and Northern England.[15] Alternatively, religious arbitration has been used to encourage women to return to abusive situations (see below for more information on religious tribunals). See cases in chapters 1 and 2 about the influence of religion in the lives of abused women with mental health problems.

Responding to mental illness

Some people within the community, however, may not understand how abuse can cause mental health problems, while others are shocked by its effects. One father said, when his daughter returned home, having left her violent husband and mother-in-law:

> *'She was crying for hours... I felt as though she was now suffering from some kind of mental illness because she cried so loudly and for so long.'*

Although some families may refuse to let women receive any treatment, others turn to their general practitioners, psychiatrists, mental hospitals and medication for treatment or to contain women's behaviour and to 'cure' them of their illness. Few trust or understand counselling or 'talking therapies'. Indeed, there is no word for counselling in the various Asian languages and even women themselves refuse counselling when offered it as it is assumed that they are being labelled 'mad'.

Many families, however, remain confused and uncertain how to assist. Many feel burdened, often hiding the mentally ill from the outside world by confining them to the home, over-medicating or disposing of them through hospitalisation. Some BME families also use forced marriage or abandonment by turning them out of the home or taking them abroad where they may receive electric shock 'treatment'.[16] Others may beat or neglect them and some seek alternative treatments, such as religious, natural or 'supernatural' remedies. The most extreme response is dictated by the belief that the woman is possessed by demons and evil spirits. In this case, the family or community may turn to an unofficial 'witchdoctor' who uses black magic to heal her, or to a priest/cleric, who drives out evil

spirits through prayer, and sometimes, even a beating.[17]

A shared experience

Women from various BME communities have similar experiences of domestic violence and mental health problems, which include religious and cultural pressures, immigration and asylum issues, suicide and self-harm, racism and discrimination, low socio-economic status or financial hardship, and the role of the health service in medicalising them or ignoring their needs rather than providing counselling or social welfare support. These issues are highlighted in a survey conducted by SBS in 2004-5 of thirty-six mental health and social care agencies (see Appendix 1). The survey also showed some differences between ethnic groups. For example, African and Caribbean women reported a greater sense of blatant racism from the health service and other agencies, such as the police and social services. Similar views were expressed by agencies which attended our consultation exercises (see appendix 2). For example, one agency said,

'A large proportion of young Asian women in Tower Hamlets are being put into hospital by their families as a way of avoiding shame in the community. Because they are disclosing sexual abuse within the family, they are being pathologised.'

THE RESPONSE OF THE STATE

Multiculturalism

Historically, SBS has challenged the view amongst some mental health and social care professionals, and government bodies, that non-intervention on issues such as domestic violence within minority communities is preferable on the assumption that cultural differences must be respected in order to maintain good race relations. Indeed, in the 1980s, this approach was epitomised by Dr Miriam Stoppard, who, in a radio interview, said that the Western model of medical intervention may not be appropriate for Asian women because there were internal mechanisms in the Asian community to deal with the problem of mental illness. This approach has led to discrimination against BME women in need of state services to prevent, and protect them from, domestic violence and mental ill health. For example, one agency in our consultation exercise (see Appendix 2) said the following with regard to the state response to female genital mutilation (FGM):

'People are so scared to do the wrong thing (on FGM) because they will be called racist, that they end up doing the wrong thing. So it is the same thing as with a lot of domestic violence. The statutory sector will not respond because it is cultural, it is traditional, you can go home now, it was two days ago and it is okay. We have exactly the same thing with female genital mutilation, 'oh, it is culture, it is tradition, it is religion, I had better not say anything just in case everybody thinks that I am not PC'. But for me, as an activist, to fail to protect an African girl from female genital mutilation is racist. If it was a little white girl, nobody would think twice. The way I look at it is, if it is not good for your daughter, then it is not good for mine.'

In 1999, the government policy of non-interference on issues like forced marriage was challenged. Mike O'Brien, the then

Home Office minister, argued for a 'mature multiculturalism', stating that, *'Multicultural sensitivity is no excuse for moral blindness'*[18] This indicated a greater willingness to intervene to protect women from abuse within minority communities. However, this approach has not translated adequately into meeting the needs of abused BME women with mental health problems. Neither the Department of Health (DH) *Delivering Race Equality*[19] and *Women's Mental Health: Into the Mainstream*[20] strategies, for instance, have led to an increase in services for BME women experiencing domestic violence and mental health problems, or, except in relation to FGM, a more proactive approach in understanding and responding to these issues within the health service. Even the *National Suicide Prevent Strategy*,[21] while acknowledging the disproportionate rate of suicide amongst Asian women, targets work on this issue under goal 2 rather than goal 1 aimed at high risk groups (see chapter 4 for more details).

Social cohesion and multi-faithism

Since 9/11 and 7/7, however, the progressive vision of mature multiculturalism, which aimed at tackling abuse within minority cultures, has been overtaken by the view that multiculturalism itself undermines social cohesion and integration between communities. Social or community cohesion policies, which are an attempt to contain Muslim extremism, promote the notion that minority communities should adopt common or core 'British values'. Tackling reactionary practices within minority communities, such as forced marriage, is dressed up as 'integration'; however these policies amount to a form of 'assimilation' based on the assumption that British values are inherently liberal and ignore the fact that oppressive practices such as domestic violence exist in the UK. It also ignores the fact that liberal traditions exist within BME communities and that BME women have, for many decades, opposed gender based violence in the UK and abroad. Draconian immigration laws are used to tackle practices such as forced marriage, in an attempt to reduce immigration under the guise of a progressive concern for women's rights. The social cohesion approach suggests that migrant and minority communities are 'to blame' for social segregation. The only differences which appear to be 'legitimate' are moderate religious beliefs which, under a new 'multi-faithism' approach, serve to encourage conservative religious identities and faith based groups with a historical antipathy to women's rights.

The growth of religious fundamentalism or orthodoxy in all religions threatens the gains made by secular BME women's groups in tackling violence against women. Even where faith or community leaders have condemned these practices, many have only paid lip service and offered little practical help to victims or BME women's groups who support them. Instead, they argue for a 'softer' approach by the state so that problems such as domestic violence and forced marriage are resolved 'internally' by educating communities through religious institutions. This approach, however, has encouraged acceptance of or support for dangerous practices such as

mediation and reconciliation by community elders, or arbitration by religious tribunals such as *sharia* courts and tribunals. These 'alternative dispute resolution' mechanisms often send women back into the home without effectively challenging abusive practices and divert them from using civil or criminal justice remedies. As a result, under multi-faithism, the state continues to collude with community and religious leaders by adopting a non-interventionist approach on women's rights within minority communities in the name of religious tolerance, thus discriminating against BME women. In terms of responses to mental health, the use of religious leaders or faith based organisations to provide therapy within BME communities, uncritically accepted by health bodies and government policy, is an example of the growing influence of multi-faithism in these treatments (see chapter 4).

Although many women who approach SBS have religious beliefs, SBS has challenged the growth of religious fundamentalism in casework, counselling and support group work as well as through campaigning, policy development and research. As a secular organisation, SBS ensures that no religion is privileged, and that believers, from all faith backgrounds, and non-believers, are treated equally and with respect. This aids cohesion within communities, allows women to understand the universal nature of patriarchy and challenges the oppression of women and other vulnerable groups by fundamentalist ideology and practices. This approach needs to be adopted by domestic violence and mental health agencies in order to provide an effective service to BME women.

Human rights obligations

Due diligence[22] must be shown by the UK government in meeting its human rights obligations which are outlined in the Human Rights Act 1998 and international conventions and declarations, including the Beijing Declaration and Platform Action 1995, the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) 1979 and the Convention on the Rights of the Child 1989. Indeed, in 2008, the CEDAW committee specifically stated in its concluding observations in the UK report that it was concerned about the higher rates of depression amongst minority women and high rates of suicide amongst Asian women. It recommended measures to address intersectional discrimination, including the provision of more voluntary sector counselling, refuge and support services, and said there was a need for [23]:

> *'...the adoption of targeted and culturally-appropriate strategies and programmes, including preventive and interventional, to address mental health issues faced by women of different ethnic and minority communities.'*

THE WAY FORWARD

This research shows that BME women continue to remain invisible because of their position at the intersection between race and gender where health and social care initiatives do not meet their multiple and overlapping needs, resulting in systemic failures in providing adequate protection from domestic violence, and the prevention

and treatment of mental health problems. Yet their needs are acute requiring urgent action, as highlighted by the following survivor, *'For every case of suicide, there are many more women needing to feel safe and sane'.* [24]

Specialist holistic services, such as those provided under the SBS model, help to prevent abuse, homicide, suicide and self-harm, and help women overcome depression, and trauma. Indeed, one service user described the SBS service to the DH Taskforce focus group in the following way [25]:

'It's such a reassurance coming to SBS... they take everything off your chest, they listen, they understand about violence, about cultural issues without us having to explain, we get support in our own language. They are a lifesaver and give you a place to scream if you want to. It's so important that it is a woman-only service because you can come here without fear in your heart. You can unload everything and go home peacefully. Services like SBS are more realistic about what to do and the right way of helping you. Unlike GPs who want us to stay with our partners until they literally kill us'

The general lack of implementation of policies and best practice in relation to violence against women in the health service has been noted by various bodies. In 2008, the Home Affairs Select Committee made a number of recommendations, including compulsory training, providing more information to women in health service settings and sharing of information and confidentiality to improve the response of the health services to domestic violence, forced marriage and honour based violence.[26]

As part of its response to this and other developments, such as the 2009 consultation on the Home Office national violence against women and girls strategy which found that women and agencies felt that DH could do better on this issue,[27] the DH established a Taskforce on the Health Aspects of Violence Against Women and Children. In March 2010, the Taskforce published its report *Responding to violence against women and children – the role of the NHS.* [28] The Taskforce Chair, Professor Sir George Alberti, stated in his introduction:

'it is a disgrace that so little has been done by the NHS so far. I urge the Government not only to accept the report but also to implement the recommendations as a matter of urgency.'

The report recommends that violence against women and children should be tackled within the NHS on the same basis as other areas of NHS work, such as diabetes and stroke. This includes increased awareness, training and education of staff support to women and children as well as improved data collection, information sharing, commissioning criteria and referral pathways between statutory and voluntary sectors.

With respect to BME women and children, the Taskforce recommends appropriate services are available and that targeted questioning should exist within the NHS on FGM for communities where the practice exists as part of an integrated local pathway of care for FGM. It also recommends that interpretation services should ensure that abuse is disclosed confidently and confidentially, and that direct treatment should be available to women and children experiencing abuse regardless of their immigration status. The Taskforce also

published a number of reports by its sub-groups and focus groups. The sub-group working on harmful traditional practices and human trafficking also recommended risk assessment procedures to improve patient and staff safety in hospitals and safe information sharing, and that guidance and indicators are developed or more effectively utilised. It also stated that evidenced specialist psychological treatments, including those based in the third sector, should be available and that independent specialist BME women's advocacy services should be commissioned.

In an interim response to the Taskforce report, the DH accepted many of the recommendations in principle, but said little about how it will ensure that the needs of BME women are fully addressed or integrated. It also specifically states that free health care for direct services for those with immigration problems will be difficult to introduce and needs further consideration.[29]

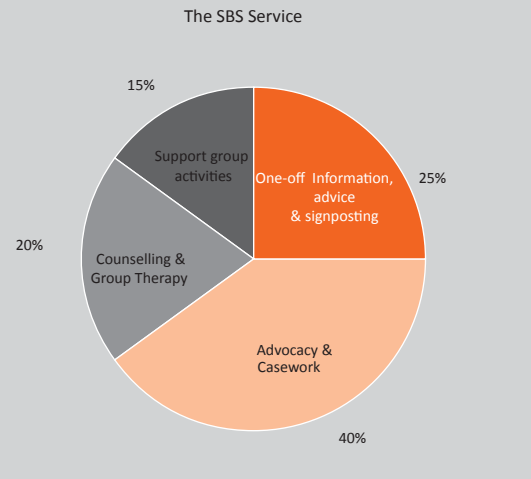
While the reports of the Taskforce are welcome as they recognise some pertinent issues affecting BME and other women and children facing abuse, and make progressive recommendations, we remain concerned that there are insufficient resources and commitment to implement them as highlighted by the DH's interim response and a poor record in completing other related programmes of work. We are also concerned that the 'Big Society' agenda of the new Coalition Government, elected in May 2010, will continue this trend as a result of major public sector cuts and an over-reliance on voluntary work rather than fully-funded service provision. These recommendations and responses do not go far enough to address the needs of BME women experiencing domestic violence and mental health problems (see chapter 4 for more details on the work of the DH and other bodies).

This report therefore advocates a way forward based on our work, and makes ten key recommendations and a number of other broad recommendations to protect BME women from, and prevent, domestic violence and mental health problems within an integrated national strategy on violence against women and girls, and a human rights framework aimed at ending intersectional discrimination based on race and gender. It also promotes a secular, progressive 'mature multicultural' approach in tackling violence against BME women and girls. See Executive summary, Evaluation and recommendations for further details.

CHAPTER ONE

Building on SBS Advice, Advocacy and Support Services

The Domestic Violence and Mental Health Project is an integral part of holistic services provided by SBS, and combines counselling and psychotherapy services with social care and welfare provision for women experiencing domestic violence from BME communities, particularly those from South Asian, African and Caribbean backgrounds. The Project therefore provides information, advice, advocacy and support services, which is complemented by formal counselling and psychotherapy (see Chapter 2 for more details). The aim is to empower women to lead independent, self-sufficient and meaningful lives free from domestic violence and mental health problems.



THE SBS SERVICE

The SBS advice and advocacy service includes the following:

- Information and signposting
- Advice about options and making informed decisions
- Advocacy or non-legal representation
- Support on one-to-one and group basis.

This could include one or more of the following actions:

- Short-term crisis intervention and/or assistance on a medium to long-term basis.
- Advice and assistance on a one-off basis, particularly via the helpline.
- Ongoing casework with a key worker/ advocate
- Risk assessment and management by identifying high/medium risk cases, taking immediate action where required.
- Accompanying and helping women to make reports of abuse, for example, by approaching the police or social services, obtaining safe housing and financial support, instituting legal action by instructing solicitors or attending court, and obtaining specialist help, such as psychiatric, counselling and other health services. The key worker liaises and works in partnership with other agencies, acting as the woman's advocate/advisor as well as providing interpretation and victim support services.
- Providing expert reports examining social, religious and cultural pressures on BME women for legal and immigration/asylum cases to assist women with domestic violence and mental health problems.
- Support group and befriending activities aimed at helping women (and children) to make friendship networks,

learn new skills and overcome stress and trauma by holding discussions, and social and educational activities. This complements the specific therapeutic support group work carried out by the counsellor.

Enquiry and casework

The Project has witnessed a gradual increase in demand as it became more established over the years. From 2001/2 to 2008/9, over a period of eight years, the number of cases and enquires nearly tripled. The majority are one-off enquiries which come from across the country, while the minority are cases mainly from the Southall or West London area.

The figures below (table A) represent the different aspects or issues dealt with in enquiries and casework and the approximate number of individual women directly assisted from 1 April to 31 March each year:

Table A: number of cases & enquiries/ women assisted by SBS since 2001

Year	Issues in Enquiries and Cases	Individual women
2001/2	351	160
2002/3	553	270
2003/4	834	400
2004/5	918	500
2005/6	930	500
2006/7	949	500
2007/8	961	500
2008/9	989	550
Total	**6,485**	**3,380**

Sample

The figures below represent a small sample which enable a more detailed qualitative analysis representing 12% (409) of the total approximate number of women directly assisted by the Project. This sample is based on individual women assisted in the Project from 1 April to 31 March each year, and have been selected where mental health issues were clearly identified to highlight common trends and patterns in enquiries and casework:

Table B: 12% sample of total number of women assisted by SBS each year since 2001

Year	Enquiry	Cases
2001/2	13	5
2002/3	16	5
2003/4	12	5
2004/5	31	9
2005/6	38	15
2006/7	65	19
2007/8	83	10
2008/9	62	21
Sub total	**320**	**89**
Total individual women	**409**	

Profile

The following profile of the sample group show a number of trends and patterns in enquiry and casework:

Age

The following is the age of the sample group (where known):

Table C: age range of 12% sample group of women assisted by SBS each year since 2001

Year	16-25	26-36	37-47	48-67	68-77
2001/2	3	2	1		
2002/3	7	6	3	2	
2003/4	9	4		1	
2004/5	9	17	5	2	
2005/6	16	19	4	5	1
2006/7	19	23	15	5	2
2007/8	19	33	21	5	
2008/9	24	25	12	9	1
Total	**106**	**129**	**61**	**29**	**4**
Overall total	**329**				

Findings:

- The majority of the sample group were aged 16-36 (71%)
- 32% of sample group were aged 16-25 and 39% were aged 26-36.

Ethnicity

The following is the breakdown of the ethnicity of the sample group (where known):

Table D: breakdown of ethnicity of 12% sample group

	S. Asian	African	Caribbean	Other
2001/2	15			1 (Moroccan)
2002/3	13	4	2	2 (Iranian, Euro)
2003/4	14	1	1	
2004/5	32	6	1	
2005/6	45	6		2 (Euro,mixed groups)
2006/7	64	8	3	7 (Euro, Iraqi Kurd, Afghan)
2007/8	77	6	3	1 (Asian/ Chinese)
2008/9	47	13	4	8 (Middle East, Euro)
Total	**307**	**44**	**14**	**21**
Overall total	**386**			

Findings:

- The majority of the sample group were from South Asian backgrounds (80%)
- A significant number were from Africa (11%).

Nationality

The sample group have the following nationalities (where known):

Table E: breakdown of nationality of 12% sample group

Year	British	Indian	Pakistani	Other
2001/2	6	2	1	1 (Bangladeshi)
2002/3	12	3	2	3 (Iranian, Somali, Bangladeshi)
2003/4	10	3	1	3 (Sri Lankan)
2004/5	24	8	4	6 (SL, Somali)
2005/6	26	10	8	8 (Jamaican, SL, Afghan, Sudan)
2006/7	31	17	10	17 (Bangla, Euro, African, Afghan)
2007/8	35	20	6	18 (Iran, Kenya, Bangla, Afghan, South Africa)
2008/9	24	16	12	31 (Somali, Egypt, Bangladeshi, Kenyan)
Total	**168**	**79**	**44**	**87**
Overall total	**378**			

Findings:

- The majority of the sample group were British nationals (44%).
- A significant number were Indian and Pakistani nationals (33%).
- Those from other nationalities have increased in recent years.

Religious background

The following are the religious backgrounds[1] of the sample group (where known):

Table F: breakdown of religious background of 12% sample group

Year	Hindu	Sikh	Muslim	Other
2001/2	2	5	5	
2002/3	3	4	6	1 (Christian)
2003/4	6	2	1	1 (Jewish)
2004/5	7	11	11	5 (Christian)
2005/6	2	15	26	3 (Christian)
2006/7	8	19	26	5 (Christian)
2007/8	18	24	25	13 (Christian, none)
2008/9	9	18	28	17 (Christian, none)
Total	**55**	**98**	**128**	**45**
Overall total	**326**			

Findings:

- The sample mainly represented the three major South Asian religions: Muslim, Sikh and Hindu (86%)
- The majority were Muslim (39%) or Sikh (30%)
- Although both groups feature in enquiries and casework, more Muslims were represented in enquiries handled through the national helpline service, while more Sikhs are included in the casework figures, which reflects the profile of the local population.

Marital status

The following is the marital status of the sample group (where known):

Table G: Breakdown by marital status of 12% sample group

Year	Single	Married	Divorced	Separated
2001/2	5	3		1
2002/3	8	8	1	3
2003/4	7	4		3
2004/5	10	18	1	9
2005/6	14	11	1	11
2006/7	20	32	1	15
2007/8	11	54	5	4
2008/9	7	51	9	6
Total	82	181	18	52
Overall total	333			

Findings:

- Most women in the sample group are either single (25%) or married (54%).
- Most married women were at the point of separation when they first approached SBS.
- Some single women may also be co-habiting, but most of these too would have been at the point of separation when they approached SBS.

Key issues

For 2001-9, the main issues confronting women in the sample group included the following:

Table H: breakdown of main issues confronting women in 12% sample group

Domestic violence	**299**
Forced marriage	**21**
Rape and sexual harassment (non-family)	**14**
Matrimonial issues (in addition to abuse)	**38**
Child welfare, residency and contact issues	**20**
Immigration, asylum and no recourse to public funds (destitution) problems	**130**
Diagnosed mental illness e.g. clinical depression or bereavement	**13**
Other e.g. debt/financial issues, alcohol and substance misuse, abortion, crime, FGM, dowry-related abuse, domestic servitude, prostitution, homelessness, racism	**47**
Total	**582**

Findings:

- Domestic violence, including forced marriage, was the main issue in the lives of women with mental health problems in the sample group (55%).
- Other major issues which featured in the lives of women were matrimonial/children matters (10%) and immigration/asylum and destitution problems (22%).
- Diagnosed mental illness exists in the minority of cases (2%).

All women in the sample group had experienced some form of emotional distress or depression as a result of domestic violence inter-related with other social issues, such as matrimonial/ children's concerns, immigration/asylum and destitution problems. Contemplated or attempted suicide or self-harm were also common features (see chapter 3 for further details). Forced marriage featured in some cases, and dowry-related abuse overlapped with many domestic violence cases. Female genital mutilation (FGM) featured in one case but this may have been a hidden issue in several cases. Honour based violence is not separated out but often cuts across domestic violence, forced marriage and sexual violence cases.

SUPPORT GROUP ACTIVITIES

Women in the Domestic Violence and Mental Health Project participated in SBS support group activities which complement casework. The activities enable women to make new friendship networks and develop skills in order to rebuild their lives away from abusive relationships. The support group activities also have an important function in helping women to overcome depression and trauma, and work in conjunction with group therapy support facilitated by the psychotherapist (See chapter 2).

The support group held weekly and annual events, which included discussions on issues such as domestic violence, health, religion and culture; socials, outings and residentials, and educational and creative classes. The attendance varied from 8 to 100 women and children depending on the scale of the activity – weekly events attracted about 8 women and day trips and large socials about 100 women and children. Residential weekends were also provided for about 8 women in Devon, Cornwall and Scotland, where activities included walking, photography, pottery classes and alternative therapy treatments.

AN SBS MODEL

The Domestic Violence and Mental Health Project developed an SBS model of holistic services to help women deal with inter-related and multiple problems. For example, a victim of domestic violence may be depressed, have an insecure immigration status and/or may face destitution because she is not entitled to public funds. Alternatively, a victim may have been forced into marriage and needs help to deal with the resulting trauma, matrimonial proceedings to obtain an annulment and safe housing to escape her family. Only a few have severe mental health problems or clinical disorders, but where these do exist, they can compound the problems. In such cases, SBS counselling services may not be sufficient or appropriate, and we work

in partnership with psychiatrists to obtain treatment. We continue, where possible, to provide assistance to the woman to ensure her safety and to resolve her legal and social problems (see the case of 'Rajinder' in Box 5 in chapter 3 for an example of this type of work in a crisis situation).

Domestic violence

The case of 'Shailender', in Box 1, illustrates how domestic violence and other issues (visa limitations, lack of family support, problems with social and psychiatric services, and access to legal advice) can contribute to mental ill health and highlights how the SBS Project helped to resolve these issue.

The case of 'Jaspreet' also highlights similar experiences in Box 2 below.

BOX 1

Shailender, a 26 year old Asian woman from India, had an arranged marriage to a British citizen and joined him and her mother-in-law in the UK. As she had a two-year spouse visa with 'no recourse to public funds', Shailender was not entitled to benefits or social housing.

Shailender was kept prisoner, locked in her home in the dark at all times. She developed panic attacks and lost all sense of time: not knowing if it was day or night. She was subjected to emotional abuse and forced to have sex with her husband from the first night onwards. She was not allowed to communicate with her family in India or in the UK or to cook meals or touch anything in the kitchen. Food was sometimes rationed to bread and water, or she would be forced to eat meat despite being vegetarian. She became frightened of her husband and mother-in-law. She contemplated, but decided against, suicide because of her strong religious beliefs.

On one occasion, when Shailender was allowed to attend a family wedding, her mother-in-law retained her passport, and refused to allow her back into the house. Shailender could not return to her family in India fearing she would bring shame and dishonour on to them. With nowhere to go, she was abandoned by her uncle at a Sikh temple in Southall where she remained for some months. Her mental health deteriorated and she became withdrawn.

The Sikh temple contacted SBS about the case. Shailender did not have the relevant evidence to show domestic violence so she had been refused leave to remain. SBS instructed new solicitors and lodged an appeal against the original refusal. The SBS psychologists diagnosed her as suffering from Post Traumatic Stress Disorder. SBS attempted to obtain psychiatric help for Shailender but the psychiatric services relied entirely on SBS to provide her with counselling.

With the support of the Project worker, counselling from the therapist, and participation in the support group work, Shailender made a good recovery and is now studying at college. She eventually won her appeal and now has indefinite leave to remain.

BOX 2

Jaspreet is an 18 year-old Asian woman who escaped domestic violence and a forced marriage. Jaspreet married in India, and joined her British husband in the UK in 2008. She was physically and sexually abused by her husband. She was also beaten and abused by her in-laws. Her mother-in-law, for instance, instigated her brother-in-law to rape her and her sister-in-law attempted to burn her to death. Jaspreet also suffered a miscarriage and when her husband and in-laws attempted to abort her second child, a nurse helped Jaspreet to escape. Jaspreet was eventually referred to SBS for assistance. During her time with her husband and in-laws, Jaspreet took an overdose due to severe depression, and continues to suffer from anxiety and trauma.

BOX 3:

After marriage in India, Gurpreet came to join her husband in Britain. She experienced abuse from her husband and her mother-in-law. Forced to sell her jewellery to pay her dowry, she was imprisoned in the house where her husband would frequently rape her. Her sister-in-law would also beat her and encourage others to do so. After a brutal beating a few months later, she was thrown out of the house. Her husband falsely told the police she was having an affair and had stolen from the family; the police took no action.

As she could not claim benefits because of her immigration status, Gurpreet was sent to live with another family member, who exploited her and made her cook and clean for the whole extended family, until she suffered injury, and complained to her GP.

Gurpreet became extremely depressed, developed an eating disorder, had trouble sleeping and suffered from anxiety attacks. In desperation, Gurpreet approached the local temple for help, but they refused to assist her because of the shame she had brought to her family. Her imprisonment, isolation and language barriers meant that Gurpreet was unaware of sources of outside help.

Her GP prescribed anti-depressants, and referred her to SBS, whose psychotherapist diagnosed Post Traumatic Stress Disorder. Gurpreet felt that SBS helped to empower her and regained a sense of self-worth: she developed a strong support network, a sense of independence, and eventually with the assistance of an SBS caseworker obtained indefinite leave to remain.

Immigration issues

The positive resolution of social problems, particularly immigration issues, which exacerbate the experience of abuse, is often a major boost in alleviating mental illness caused by anxieties about an uncertain or dangerous future. See the case of 'Gurpreet', in Box 3 .

Harmful traditional practices

Domestic violence can take various culturally specific forms, such as forced marriage and so called 'honour' based violence. Conservative religious and cultural value systems can be used to perpetrate these harmful traditional practices, which can play a key role in causing mental health problems, where abuse is justified in the name of

'My parents told me that I had to go back and make the marriage work. They were worried about how this would be seen in the community, and how they would be dishonoured by my very presence ... some people in the community put pressure on me to reconcile with my husband so that I would not continue to bring dishonour. When I have to tell people that I am divorced, no one asks why. They only assume that I must have been wrong, that it was my fault. They want me to die at home with my husband rather than leave him.'

family and community honour and/or women find it difficult to leave an abusive situation for fear of bringing shame and dishonour. The words of 'Gurpreet', (see p 26) who suffered depression as a result of pressure to remain with her abusive husband, illustrate this powerfully.

(Also see the case of Banaz Mahmood, who was subjected to an 'honour killing', below.)

The role of forced marriage in causing depression is highlighted in the case of 'Anisha', a young woman of Pakistani origin, whose father removed her from college when he suspected she had an English boyfriend. Kept in isolation within the family, Anisha (Box 4) feared she would be forced into marriage. She made her escape and went to live with her boyfriend.

The case of 'Samina' (Box 5) highlights the growing influence of conservative religious values in the lives of women.

BOX 4

Anisha's family reported her missing and sent messages to her via the police. When one of her sisters became ill with cancer, Anisha visited her in hospital until her death. She agreed to go to the funeral that her parents had arranged in Pakistan, on condition that she would not be forced into marriage.

After the funeral, Anisha was informed that she was to marry a cousin to whom she had been engaged from a very young age. Without access to telephone, money or passport, Anisha could not get help. She became very depressed and contemplated suicide. She was forced into marriage – her 'consent' was assumed when her mother pushed her head down her three times during the Islamic ceremony. Once married, Anisha's husband raped her.

When she did not return to Britain, Anisha's boyfriend approached SBS for help. SBS contacted the Foreign and Commonwealth Office, who, having failed to contact Anisha in advance, made an unsuccessful visit to her husband's house in Pakistan.

Months later, Anisha persuaded her husband to let her return to the UK so that she could sponsor him to join her. She met SBS who helped her and her boyfriend move into safe accommodation. However, as she was in another part of the country, SBS could not offer her its counselling services. SBS helped her to obtain an annulment from her husband: the case set a legal precedent as the first annulment of a forced marriage in England. Anisha said this 'now proved that I am single as I never regarded myself as being married'. Anisha also reported feeling more confident about her future and less depressed as a result of the help she had received from SBS.

BOX 5

Samina came from Pakistan to join her husband in 2007 at the age of 22. Samina contacted SBS in June 2008. She had become homeless after her in-laws threw her out of the matrimonial home and her brother refused to support her. Samina had been subjected to domestic violence and honour based violence from her in-laws; her husband regularly incited his family to beat her. He claimed that as a 'devout Muslim', he could not actually beat her himself, but used his position and beliefs to ensure that his family did so. Samina was not allowed access to council housing or benefits because of her insecure immigration status. She had been diagnosed with Hepatitis C and had become severely depressed. SBS helped her to recover through counselling, advocacy and support.

Non-Asian women

BME women from non-Asian backgrounds also share similar experiences of domestic violence and mental health problems (also see Appendixes 1 and 2 on the experiences of other agencies working with women from a range of ethnic backgrounds). Box 6 below highlights 'Naila', a woman from Somalia, who as a child experienced female genital mutilation, and subsequently domestic abuse when working as a domestic servant in Somalia; in the UK she was destitute, refused asylum, and forced into prostitution until SBS intervened.

BOX 6:

Naila suffered physical and mental abuse from members of the family she worked for as a servant. The son of the family, who eventually married her, raped and abused her. In Somalia, she had felt suicidal.

Following the civil war, Naila's husband arranged for her to come to the UK, but could not travel with her. In the UK, she was destitute. She prostituted herself for money. She felt abandoned and suicidal. She was also malnourished with no access to housing or support from the state. Her asylum application was refused.

Naila found out about SBS, and we helped her to appeal against the Home Office refusal by changing solicitors. SBS also helped her to make new friends and support networks through the support group activities. In addition, she received counselling to overcome her trauma, which included symptoms of being withdrawn, worried and fearful. However, she still continues to feel anxious about her pending asylum appeal.

Additional social factors

Some women assisted by SBS had additional problems which contributed to their difficulties. These included a few women with alcohol, drug and substance misuse problems, and those in prison or in detention centres. Three women with immigration problems, for instance, were held in a detention centre. They complained of depression and trauma brought on by the experience. One attempted to set herself alight when immigration officials tried to deport her. Another woman who had three small children detained along with her found that they also developed physical and mental health problems.

Extreme cases

Some of our cases included women who had killed their violent partners, who had been killed by their husbands or families, or who were driven to kill themselves (homicide and suicide cases are not included in the sample group. Suicide cases are discussed in more detail in chapter 3). These cases represent the extreme end, and often involved a history of depression or emotional distress caused by domestic violence.

The case of Zoora Shah in Box 7, below, reveals the impact, and extreme consequences, of abuse on the mental health of BME women. The case also reveals the state's failure to recognise the impact of abuse and to provide effective help. It highlights the importance of and need for holistic services like those of SBS.

BOX 7:

In 1992, Zoora Shah, a woman from Pakistan, was convicted of the murder of a man with whom she had had a long-term relationship. He had subjected her to economic and sexual exploitation, including rape and prostitution. She was jailed for life at Leeds Crown Court in 1993.

Her appeal against conviction for murder was unsuccessful. Her case, along with other high profile SBS cases, has been at the forefront of the debate on how the law should treat abused women who kill. The case highlighted the failure of the criminal justice system to recognise the impact of domestic and sexual abuse, as well as prostitution, on Asian women.

In 2000, SBS successfully worked with her lawyers to reduce her tariff from 20 to 12 years. SBS was instrumental in ensuring that Zoora Shah was transferred to an open prison before the final parole hearing, and in 2006, she was released on parole.

Prison support was provided by the Project Worker. As the prison service had failed to provide regular counselling to help Zoora's rehabilitation, which adversely affected her chances of parole, SBS was compelled to intervene. The SBS counsellor undertook intensive counselling to enable her to overcome trauma. Counselling was crucial in that it allowed Zoora Shah to gain insight into her actions and predicament, express regrets about her actions in appropriate language (there was considerable cultural misunderstanding about how she was expressing remorse) and learn how to manage future risks and dangers – all of this helped to show the parole board that she was fit to be released into the community.

The prison later asked SBS to provide similar specialist counselling and advocacy services for other BME female prisoners due to a lack of resources and expertise. SBS was unable to do this due to limited availability of specialist counsellors and advocates. The case highlighted the need for more such provision in women's prisons.

BOX 8:

Banaz was killed for bringing dishonour to the family by leaving a violent husband and forming a relationship with a man deemed 'unsuitable' as he was from another tribe.

Before her death, Banaz had seen a psychiatrist about her depression and history of self-harm: the result of the abuse she suffered from her husband and her parents – abuse which had led her sister Bekhal to leave home as a teenager. This experience and that of the murder of her sister had a profound effect on Bekhal's mental health.

In her personal impact statement at the hearing on sentence, she said: 'I find it really hard to say how much her death has affected me. Words just do not say enough ... I can honestly say there's not been one night without having nightmares. Banaz herself does not come into my dreams or nightmares, and that upsets me. I would like to see her again…I cry and become very upset when I think what has happened to her. My life will never be the same again'. [2]

SBS has worked on other cases involving murder or so-called 'honour killings'. SBS became involved in the case of a 19-year-old Iraqi Kurd, Banaz Mahmod, in 2006 after her body had been found in a makeshift grave. SBS supported Banaz's sister, Bekhal throughout the murder trial of her father and uncle, who were convicted of her murder in June 2007. One other man admitted killing Banaz although two others fled the country to escape justice (see box 8).

CONCLUSION

The SBS model highlights the need for holistic specialist services in tackling domestic violence and mental health problems among BME women. The model combines advice, advocacy and support services with counselling and psychotherapy (see chapter 2 for more details on the therapy services) in order to meet the multiple and intersecting needs of women subjected to abuse. The statistics provide a profile of our service users while the case studies indicate how domestic violence, harmful traditional practices and inter-connected issues such as immigration form the underlying causes of mental health problems, suicide and self-harm (see chapter 3 for more detail on suicide and self-harm). They also show how our model of intervention is effective in addressing these problems. (See Executive Summary, Evaluation and Recommendations for an evaluation of the model and recommendations.)

CHAPTER TWO

Developing a BME Gender Hybrid Model of Therapeutic Interventions

A complementary part of the SBS model involved providing an in-house formal counselling or psychotherapy service for women who were escaping domestic violence. This was provided by Shahrukh Husain. The group therapy sessions were also supported by Meena Patel, the Domestic Violence and Mental Health Project Worker. They were able to provide a service in English and a number of Asian languages. The clients were referred by our caseworkers from the women with whom they were already working. Referral criteria included women displaying signs of depression, anxiety, severe distress and suicidal thoughts or self-harming behaviour.

The therapist developed a new hybrid therapeutic model targeting the needs of BME women, particularly South Asian women, experiencing domestic violence. This model used a new method of working which combined established therapies in a fluid way, allowing for some relaxation of boundaries and flexibility in communication, and using, when necessary, some directional elements drawn from Life Coaching. [1]

From the onset, in 2002, the therapist noticed that some women initially required to be 'prepared' for therapy, which aimed at improving their functionality to deal with their most pressing needs such as malnutrition and insomnia. To ensure that they attended, these clients needed immediately to experience the 'holding environment'.[2] This was achieved by firstly listening carefully, mirroring and *engaging.* Unlike in other therapies, it was vital to convey care and concern more obviously. The object of the boundary bending was to enhance the holding environment, provide a goal and fulfil a duty of care to a group of women so depressed through isolation and emotional deprivation that they did not believe they were of significance to anyone. This was often done in the first few sessions following the assessment stage.

Following this stage, principles of humanistic,[3] cognitive-behaviourist[4] and psychodynamic[5] therapy were used at various stages. From 2005 to 2006, there appears to have occurred an organic refining of these standard therapeutic techniques when elements of Life Coaching, particularly small, timed targets building up to a major goal, were introduced along with stress-relief techniques. This meant there was practical/preparatory work at the beginning and goal-orientated work at the end. This facilitated clients taking control of what is controllable in their lives and accepting that some things are out of their hands such as pending Home Office decisions on their immigration application or what happened in the past.

KEY ELEMENTS OF THE MODEL

Stage 1 – Assessment

In general, facilitated by our assessment questionnaire,[6] the initial two or three sessions allowed the client to express the pent-up distress, humiliation, confusion and grief of her recent past. During this time, relaxation exercises, meditation and stress-relief techniques were introduced. If the

client reported tiredness, dizziness, general feeling of weakness, insomnia or loss of appetite, elementary nutritional advice was given and a routine developed which involved getting up at a particular time in the morning and leaving the house to take exercise. This then led, more or less naturally, to setting short-term goals and developing a list of tasks that must be undertaken on a day-to-day basis: these would include food shopping and cooking; exploring local areas; researching and trying out local transport; practising English, perhaps in a shop, on the buses or another functional opportunity. The model also worked on developing assertiveness, occasionally using role-play during which the client would develop short 'scripts' for specific situations.

Stage 2 – PTSD management

It would be true to say that the majority of clients attending therapy sessions at SBS could be categorised as survivors under the Battered Women's Syndrome (as developed by the Survivor Theory)[7] exhibiting elements consistent with Post Traumatic Stress Disorder (PTSD).[8] (See Appendix 3 for more details on PTSD.) The management of PTSD often involves a combination of interventions with equal emphasis on humanistic therapy and cognitive-behaviourist work.

The model began with four, often more, sessions of humanistic work which have proved to be vital for several reasons. It was at this stage that the client:

(i) became aware that she was now in an environment where her experiences and traumas would be acknowledged without censure.

(ii) could express her emotions and work through her feelings of victimisation.

(iii) felt she was in the presence of someone who believed in her ability to survive and go on to make a life for herself.

(iv) learned that despite the fact she could not manage to stay in her marriage, she was valued and her predicament accepted for what it was. This was vital to Asian and other minority women where morbid importance is placed on 'honour' and 'shame' in a society in which women are the scapegoats as well as the guardians of family honour.

It was in this first phase that the women were allowed to grieve, and began to be aware that they were the victims and survivors of profound mental and physical abuse and that society's attitude to them may be unjust and wrong. They also got past their shame sufficiently to be able to reveal their experiences. If introduced to it prematurely, clients experienced the introduction of Cognitive Behaviour Therapy (CBT), which includes reading, task-setting and achieving goals, as yet another set of impositions. Consequently, it did not work and they either failed to fulfil their 'tasks', or did so merely in order to avoid the risk of losing support by annoying an 'authority figure' through 'disobedience'.

Stage 3 – Looking back and facing the future

Finally, the client moved on to looking back, reviewing the trauma, where necessary, using such techniques as

'thought flooding' to mediate the trauma and attempting to visualise the future and various eventualities. Often with the SBS constituency, where immigration is a major issue, the client finally reached a stage where she could begin to discuss the possible options available to her if she was forced to go back to her country of origin.

This stage started about halfway in therapy sessions. When the client had acquired some insight, self-awareness and a level of self-empowerment, psychodynamic work was added to the process. It has generally proved to be appropriate for clients to look back with a more open mind in the light of their nascent psychological independence, to possible social injustices in the society of their upbringing and also within their families. It was at this point that they were able to express anger, hurt and criticism of their family and community without feeling too much guilt. This gave them some self-worth and contextualised their experience. It was at this point that embedded perceptions and attitudes were transformed to some extent thus rehabilitating clients in their own minds as 'good people'. Though clearly more extreme in women of South Asian origin, the attitudes described above are common to most women who have been subjected to domestic violence.

Code of ethics

The Project adopted the UK Council for Psychotherapy (UKCP) Code of Ethics. Five letters, as required by the code of ethics, were drafted for clients, which included:

1. Offer of assessment and explanation of service procedures such as the waiting list etc.
2. Offer of appointment explaining boundaries such as regularity of attendance, punctuality, cancellation procedures
3. Letter regarding first session missed without notice, inquiring after client and requesting that the centre be informed about their next session. Reminder that sessions missed without notice are not replaceable and, that three consecutive sessions missed without notice result in therapy being terminated.
4. Letter regarding second missed session reiterating all of the above.
5. Letter terminating the therapy contract.

In practice, much of this was done face-to-face or by telephone because caseworkers were constantly in touch with clients and able to remind them more informally of the agreement. This worked better as some clients could not read English and others may have taken the letters as a reprimand.

THE PSYCHOTHERAPY SERVICE – THE EARLY STAGES

Psychotherapy sessions began at SBS premises in April 2002 with four women referred to the psychotherapist by the Project worker. The initial intention was to assess a sufficient number of clients to start up a therapy group. However, it was immediately obvious that none of the women assessed was immediately suitable for group therapy for the reasons outlined below:

- Feelings of shame
- Fear of being judged
- Fear of contamination (i.e. being made to feel worse by the disclosures of others)
- Lack of trust in the confidentiality process and exposure to community resulting from it
- Unwillingness to open up in the presence of others

It was immediately clear that all four clients required urgent one-to-one assistance, being full of distrust yet desperate to tell their story, suffering from insomnia, flashbacks, intense grief, tension headaches and inability to eat or cope with daily life as well as obsessing about their situation and asking repeatedly why they had been put in this position. It was therefore decided that it was necessary to provide individual therapy preparatory to joining a small, open group in due course. Candidates were to be offered the opportunity to join the group on re-assessment at termination of individual work. It was difficult to gauge just how long this preparatory period would take since the women were at varying stages of resistance.

Assessment

The first four clients were all of Sikh origin and shared certain cultural attitudes with other South Asian women, primarily, exaggerated awareness and fear of the consequences of their situation as 'rejected' women. These concerns had, in most cases, exacerbated the women's distress taking their anxiety to a level almost of paranoia. It related primarily to their personal lives – fear that the break-up of their respective marriages would be 'discovered', causing 'gossip' and forcing them to face disgrace and disrepute. This anxiety, though apparently illogical, is nevertheless the result of a very real and widespread situation in which women of Asian origin find themselves following the dissolution of marriage. They are stigmatised, held responsible for dishonouring their birth families and ostracised. Several of them fear being beaten and persecuted if returned to their birth families and do not discount the possibility of murder. Preferable to the dread and uncertainty of extreme humiliation and death by another's hand is the option of suicide.

All the initial four women had experienced a violent marriage break-up: two had broken up a few years before the start of therapy, and two within the last year. Three women had suffered severe domestic violence, two experienced serious sexual assault and one had self-harmed and attempted suicide while drunk. With overriding issues of shame and disgrace, it was untenable for them to discuss their private experiences in a group, even if this was a collective group problem. Each woman said she had never come across divorce in her family or community. Thus the concept of a community of women with broken marriages was an alien one. Unconsciously, it appeared, they had internalised the social taboo and maintained the same attitude as their family and community.

These issues are highlighted by the case of 'Renuka', Box 1, who despite being abandoned by her husband and his family was at pains to dress and behave 'like a

married woman at work':

BOX 1:

Renuka's marriage had broken up. Her husband, it had emerged after the wedding, had the mental age of a child. Her mother-in-law had moved her out – with no resistance from her husband – to a rented room. She worked in a factory, mainly managed by men, and kept to herself. She would still let herself be seen with her husband when he came to give her occasional lifts home, so she could 'retain the status of a married woman' in the eyes of her co-workers.

On probing, Renuka explained that a divorced or separated woman 'has no status' and that 'they will gossip about me and assume that the split was my fault. They will ask each other what my misdemeanours might have been. Then they start asking if I have my stay (in the country) and start trying to suggest inappropriate matches.'

The case in Box 2 below corroborates the widely-held view that if a husband throws out, or leaves, his wife she will have no status.

Consequently, in order to avoid humiliation and exploitation, women suffer from severe self-imposed isolation. Initially, women who had been assessed were offered 12 weekly sessions with an option of a further 12 weeks to run consecutively following further assessment. In view of the intense quality of suffering and trauma, the long period over which it had been endured or, in immigration cases, the spectre of deportation looming large, 26 weeks seemed the more humane and practical period for therapeutic intervention.

BOX 2:

'She's far worse off than a woman who has never married – and being unmarried is bad enough. In my position, I'm an undesirable woman, I'm immoral or 'bad' in some way and can corrupt other women – except of course when I'm useful. If I let people know my situation, I'll be treated like common property. People will think I'm up for grabs. Men make advances and women ask me to visit and then get me to do menial domestic jobs or constantly try to fix me up with relatives who need a passport or because there's something wrong with the guy.'

The client list grew swiftly. In the second week, one more woman was assessed and in the third week, a further two. By June, there were eight regular clients. Word was getting round about the clinic and the waiting list was growing. The clinic expanded to a full day with a diary of eight clients. New assessments and emergencies were slotted in at lunch time and during any other free hour and in the spaces left by cancellations. However, it was noted that in most cases, having spoken out at assessment about their traumas and concerns, often for the first time, the women became more fragile as vulnerabilities came to the surface. This meant that it was necessary to provide therapy as soon after assessment as possible.

The waiting list was superseded in

case of emergencies. 'Emergencies' were defined as acute situations in which a client required crisis intervention in order to alleviate suffering, prevent pathologies developing in the longer-term and avert possible self-harm, suicide or other extreme measures. Unfortunately restricted resources resulted in limited sessions and the waiting list grew dramatically.

The case study of 'Harinder' in Box 3 below provides an example of emergency SBS support for a woman whose sons were being deported.

As sessions were established, the psychotherapist maintained week-to-week bookings of regular clients. The Project Worker dealt with the waiting lists and to book assessments. The only problem with the appointment system was the growing waiting list resulting from only having one therapist and one clinic day per week.

Group therapy

Therapy Group One

The first therapy group began in February 2003. This consisted of four women who had each been in therapy for a minimum of 26 weeks. Having spent a significant time in one-to-one therapy already, the four members were immediately able to make excellent use of the group. After the first three sessions, which used artwork, sand-play and narrative to reveal and explore the experiences in their past, members decided they wanted a closed group. Entry to the group was thus closed off.

Subsequent group sessions were based on Egan's 'Skilled Helper' model as set out in the example below[9] and involved working through its various stages employing art therapy and creative visualisation to discuss and analyse 'blind spots'. On review,

BOX 3:

'Harinder' approached SBS the day before her two young sons were due to be deported to India. Her husband's Indian lawyer had established in court that she had 'abducted' their children. This was at odds with Harinder's view: she had come to England with her husband's support; stayed with his family before her father-in-law attempted to set their mattress on fire while she and her son slept. Moreover, Harinder's husband was an alcoholic, had not been in contact with the children for a year in the UK, nor had he had any relationship with them when they all lived together in India.

She was given a double psychotherapy session after the last booked appointment to assure her of full emotional support and provide a safe space in which to express her grief and deal with her immediate crisis as best she could. She was assured SBS would provide legal support should she wish to contest the legal action.

During sessions prior to, and following, her handover of the boys, she was shaken and exhibited all the signs of bereavement. Her main fears were that the boys' father would not bring them up with affection and due care; that they would forget her or grow up hating her. However, she was able to focus on ways in which she could ensure that they received some affectionate care and she resolved to contact her mother to keep an eye on them.

it was found that each session brought fresh revelations and breakthroughs, as trust grew and certain factors surfaced which had not materialised in one-to-one work. It was further noted that the envy felt in the group at inception was transforming into fellow feeling and participants were able to enjoy each others' triumphs. From the first session, the focus was on encouraging clients to identify goals, moving towards the removal of psychological obstructions which had held them back from functioning at their best. Cognitive behaviourist ideas were used at various stages of the process. There was remarkable, measurable change by the end of a 12 week period.

Table A below charts the progress of the individual members of the group 'Shashi', 'Renuka', 'Gogi' and 'Gurinder'.

Therapy Group Two

The second group, which was initiated in July 2005, was organised to provide a 'holding' phase for clients who had been on the waiting-list for a long time. It proved that the first decision (i.e. to institute group work only after clients had worked through a period of individual therapy) had been the right one. Once again, the group began with four women, opening with each woman introducing herself briefly. One woman, 'Sabby' (50), launched immediately into a chaotic and desperate account of her relatively recent rape, her abusive son, sexual abuse in early adolescence from her father and brother and various complaints against her siblings. Though several interventions were made to give space to other group members, Sabby continued to interrupt with more details of these traumas, adding also that she had recently been ejected from her drop-in centre because other users had complained about her. Though the group was stabilised by the facilitators, and the younger women were able to make suggestions about their hopes for it, one woman, Viki, rang later to say that she had found Sabby very difficult and did not wish to attend further groups. A second client also found Sabby overwhelming, though she was prepared to give the group another go. It was decided we would have one more session to close the group but Viki was not willing to attend. She was offered individual therapy soon afterwards but declined.

TRAUMA OF DOMESTIC VIOLENCE

The chief presenting problem and the main cause of psychological trauma in most cases was domestic violence of differing levels, generally from Asian husbands and in-laws, of British nationality against women brought from India or Pakistan, through marriage, or by their own parents and siblings. These reached unbearable levels, in some cases, forcing women to leave home or to seek help from the police. As frequently, women were thrown out and found themselves homeless, living in temporary rented accommodation or refuges, or with relatives or friends and under immense pressure to move out.

The following were some key issues related to the experience of domestic violence highlighted in therapy and linked to women's depression and traumas:

Table A: *chart of the progress of four individual members of Group 1*

STAGE 1	STAGE 2	STAGE 3
Current Scenario	Preferred Scenario	Action Strategies
1a - The story (What's going on?)	***2a - Possibilities (Ideally, what do I want instead?)***	***3a - Possible actions (How many ways are there?)***
1.Shashi: no time; everyone's 'sucking me dry'; alcoholic brother; kids; she stays out all day to avoid unwanted visitors and avoid family demands.	1. Shashi: to find more time for herself. To be able to tackle backlog of important tasks. To take her kids away on holiday. Spend stress-free time at home.	1. Shashi: learn to state her needs; to plan strategies of dealing with unwanted visitors without offending them; to be open with family members who make demands; to learn to ask for help from family and friends. To stop trying to be everything to everyone. To plan some rewards for herself.
2. Gurinder: felt powerless and told stories about how men seemed to see her as 'fair game' because she was single. Women either exploited her or dismissed her.	2. Gurinder: To stand up for herself; to nip unpleasant behaviour in the bud; to stop feeling she has to apologise for herself; to do as she's asked for fear of being rejected; to stop being ashamed of herself	2. Gurinder: to be more direct; to practice affirmations; to discuss strategies within the group, of dealing with exploiters.
3. Renuka: withdrawn at work, with husband	3. Renuka: to be more integrated at work;to	3. Renuka: to make a little more effort to join

1b - Blind spots (What's really going on?)	***2b Change Agenda (SMART goals)***	***3b - Best fit strategies (What will work for me?)***
1.Shashi: Desperate to be liked and admired. Harks back constantly to the 'traumatic event' because it achieves the above and validates time away from home and family for legal and health appointments. Thus she gets some personal time without offending anyone. Also, going on holiday involves contact with her husband's solicitor as her husband kept hold of the children's passports – and she's afraid this will raise demons.	1.Shashi: try to move away from the past by avoiding reference except when strictly necessary; focus on what she can achieve and change what is changeable; transform negative thinking; explore what she'd like from the future.	1. Shashi: Visualisations about the future; get hold of Floodlight or similar and explore courses of interest; see careers advisor about possible jobs bearing in mind severe medical problems resulting from trauma. This will prevent her from exploiting her trauma for sympathy and admiration and to provide genuine reasons for needing time of her own.
2. Gurinder: profoundly ashamed of being 'abandoned' by husband; feels trapped in the marital flat with memories of humiliation; feels her desire for a new husband is degrading.	2. Gurinder: to find somewhere to live; get back some autonomy; stop feeling ashamed of her wish to remarry.	2. Gurinder: will discuss housing options with Project Worker; have a thorough reality check about her feelings on women in her position vis-à-vis marriage; use sessions to work on her self-image; reflect on some marriage proposals and introductions offered by friends and well-

and in group; has outbursts; says all she cares about is getting her visa.	be able to think beyond the grief and humiliation of the past year.	in at work, maybe with the odd comment or smile or greeting; to make a list of positives, e.g. her husband leaving his mother to live with her; to use the group to work on areas of her life where she can be proactive; to develop techniques to change her negative thoughts to positive ones.
4. Gogi: feels indecisive; exploited by adult children; constantly guilty; overworked; emotionally burnt-out; in agonies about plight of her five 'orphan' nephews and niece.	4. Gogi: To stop feeling guilty about asking for help from her adult children; to ask for what she wants instead of waiting to get desperate; to stop feeling guilty about everything; to live harmoniously with her family and be less desperate about money.	4. Gogi: To set out what she expects from her kids who are both working, work out what she feels is reasonable to ask for and test it in the group; to then discuss these contributions to household finances and tasks and to discuss it pleasantly, inviting opinions and suggestions rather than 'acting out' or laying down the law.

		wishers. (She found a boyfriend very soon afterwards.)
3.Renuka: intense rage, partly existential with several recent deaths in her family which bring her face to face with the possibility of her own death (which she maintains she will bring about if threatened with deportation); she loves her husband but he has the mental age of a 12 year old and she is burning with anger at the deception; there is no sexual interaction, though they occasionally kiss. She has concealed her husband's mental development and the sexual problems from the group. She has issues of trust in general.	3. Renuka: wants a proper marriage which includes a proper sex life; she will ask him to behave like a proper husband; contribute equally to living expenses; stop running every time mum tugs the apron-strings; she wants to stop feeling angry and isolated.	3. Renuka: will brace herself to discuss the issues with her husband; do her best to bite back her sarcasm; try to explore which demands like visiting his mother are reasonable; also to remember that loyalty issues aside, his mental state and his way of relating to his mother are different to hers; she will test out these aspects in the group; she will, further, use the group to express her anger
4. Gogi: frustrated with years of self-neglect; terrible misfortunes; carrying the burden of parentless nieces and nephews and their problems with their maternal grandparents who are their carers; trying to compensate for the tragedies and mishaps in the lives of those around her. While trying to achieve the impossible, she worries life will slip away before she can experience fulfilment.	4. Gogi: wants to find more stability in her life and more space in it for herself; she wants to have time to think about what she wants in life; where pleasure lies; what she deserves; how to get rid of the guilt and find freedom and fulfilment. She would like to do things independently, e.g. buy herself an outfit without endlessly agonizing about it and repeatedly consulting others.	4. Gogi: she will make a dream-list,things she missed out on; things that tempt her but she denies herself; she will get more help from her children and think hard about what she takes on; she will work on treating herself to something without consulting anyone and without asking anyone's permission

Table A: *chart of the progress of four individual members of Group 1 (cont'd.*

1c - Leverage (Focussing/ prioritising)	*2c - Commitment (Check goals are right)*	*3c - Plan (What next and when?)*
1. Shashi: will concentrate on planning a holiday.	1. Shashi: will go with her sister and family to ensure she has adult company she enjoys, the children will have other children to play with and childcare will be shared.	1. Shashi: has committed to getting the passports from her husband's solicitors (a huge stumbling block for her); she will renew the passports; she will book her tickets. All this will be done in the four remaining weeks of group meetings.
2. Gurinder: will break up with her boyfriend. She felt he was with her because he believed she was on the verge of getting leave to remain. He had also spoken to her threateningly and was becoming possessive.	2. Gurinder: is sure he is wrong for her and she wants to get rid of him before she acquires the keys to her new flat.	2. Gurinder: felt she did not want to reveal to her boyfriend either that she had got leave to remain, or that she now had a flat. She also wanted back some group photos in which they both appeared which he had sent back to India without her permission. Group said pictures were not important so she should let that go. They agreed that if she was breaking up with her boyfriend, she had no obligation to tell him about her life anymore. She should simply tell him she didn't want

		to continue seeing him.
3. Renuka: would stop 'acting out' and have a frank discussion with her husband about what was upsetting her.	3. Renuka: her main priority was to get things right with him and to stop fretting about her 'stay'. Project Worker said that though these things can never be guaranteed, on balance Renuka's case was very strong, specially now she was with her husband.	3. Renuka: would try to use the group to allay her anxieties and to accept that uncertainty was a feature of life; to concentrate on positives and express anger when she felt it, making it clear what she was angry about.
4. Gogi: will buy an outfit. It will be for fun and frivolity, brightly coloured and not necessarily practical.	4. Gogi: found an outfit – yellow, fancy, very contemporary. She is going to find the money and buy it.	4. Gogi: will take the money out of the contributions her children are now paying her. She will save elsewhere and just go for it!
Action Leading to Valued Outcomes		
Shashi, Gurinder and Gogi achieved their goals which fitted the SMART criteria (an acronym from management terminology used in Life Coaching to set goals: Specific, Measurable, Achievable, Realistic and Timely). Their attitude towards themselves changed tangibly. On summing up, they felt cheerful and confident that they had acquired skills which helped them to value themselves more and therefore to stand up for themselves and reach out for what they wanted. They were slightly less concerned about gossip and back-biting from society. Renuka's goals were less clearly identified and were also far less achievable, being unspecific. Though her anger was beginning to be more manageable, she had a severe setback when Gurinder received leave to stay. However, she did start to make a little headway in communicating with her husband and was also trying to build bridges at work. She felt she had learned more about herself and was trying not to cut herself off emotionally and socially.		

Grief, shame and dishonour over break-up of marriage

The case study in Box 4 below is an example of the effects of grief, shame and humiliation on 'Shailender' who became withdrawn following the break up of her marriage:

In similar cases, when husbands and in-laws turned against women, the women became significantly disoriented, constantly asking unanswerable questions, going over the same ground repeatedly. *'Why did this happen to me?', 'How could they do this to me?', 'Where will I go?', 'What will become of my life?'* Though they were often in their early twenties, they believed their life had ended and that there was no future for them. This was because Asian society, in the majority of instances, offered them no refuge or sanctity as disgraced women who were accused of bringing shame and dishonour. Such women were treated in their communities as pariahs. They were censured; young women were told not to communicate with them for fear of being corrupted; family and friends pressured them into remarrying and accepting inappropriate matches. They were constantly chided, made to feel a burden and often beaten and taunted. They were also threatened with their lives and feared being locked away, starved or beaten to death.

Child related issues

Women in this client group (i.e. survivors of domestic violence) were often 'foreign-brides'. They lacked Western education, and sometimes had no education at all. They were also not allowed much experience of British society, and found themselves powerless and confused and often felt unsupported by the relevant authorities.

They reported the following threats:

- That their in-laws had threatened them with deportation (even where they

BOX 4:

Following domestic abuse from her husband and mother-in-law, Shailender's own family persuaded her husband to let her attend a cousin's wedding; on her return he refused to let her back into the marital home. She had no idea where to go or how to find accommodation. Having never been out of her marital home she had no idea about life in England. After giving her a roof for a year, her uncle deposited her in the Gurdwara (Sikh Temple) where she remained on sufferance. Once a day she left the small room she was allocated to eat something from the temple kitchen.

She felt shame at being abandoned by her husband, grief at being rejected, and humiliation at being cast out, homeless and living on charity for all to see. She became isolated. By the time she arrived at SBS she was profoundly withdrawn and suffered panic attacks in the session, possibly because she was being expected to interact. She was unable to stand up when the session was completed. Following her first assessment, SBS took the unusual step of having her admitted to hospital for psychiatric assessment – this confirmed a diagnosis of clinical depression and she was prescribed anti-depressants.

had received British status) and that their child, being British born, would be taken from them and kept here with the support of the British authorities who were set up as being inimical to the newcomer and unequivocally on the side of British citizens in all circumstances.

- That their husbands had threatened to besmirch their reputations or to have them raped, beaten or killed. Some husbands had threatened to track them down and kill them personally if they 'try to leave'
- The women believed the threats because they knew of cases where this had actually occurred in the countries of their origin
- They became fearful of facing their husbands even in controlled conditions in child visitation centres or in court.
- They constantly feared their child would be 'snatched' and became hyper-vigilant with exaggerated startle-response
- They believed that because they were not conversant with the local culture that social workers and other key workers or supporting agencies would collude with the husband and his family who were able to 'fit-in' better and make themselves better understood
- Worst of all, they feared that their child would be taken from them as the direct result of their inability to communicate or convey their position accurately, and given to the husband and in-laws
- They also feared that if the husband and his family were given visitation rights or the right to have the child overnight or for weekends, that they would begin to indoctrinate the child against them on the one hand (with a view to one day taking the child away) but ill-treat the child on the other hand. The last is based on past experience.

The case study of 'Jagat' in Box 5 is an example of a young mother who was forced to leave her newborn daughter with in-laws. Their apparent ill treatment of her baby, and their injunctions, compounded her fears that they exerted considerable legal power. Her survival techniques complicated her relations with social workers until SBS was able to intervene.

There were subsidiary concerns in Jagat's case:

- that the family would feed the child meat (many of the women are vegetarian as a matter of their deeply-held faith). For instance, once 'Jagat's mother-in-law had done so to taunt her.
- that the child might pick up destructive habits in the husband's environment. Jagat's sister-in-law drank heavily as did her father-in-law and occasionally, her husband, too.
- The clients' anxieties appeared to proliferate, one touching off another, until the situation was magnified to an unbearable degree and became impossible to contain.

In some cases, these proliferating anxieties became so persistent and overwhelming that clients began to exhibit delusional thoughts, as illustrated by the Samar case below (Box 6).

In cases of proliferating anxiety, the

BOX 5:

'Jagat's in-laws insisted she go back to work within weeks of the birth of her daughter. On the first day back from work, she reported that she found her baby had been left for hours in a dirty nappy and her nappy area was lacerated and red raw. It seemed that the baby had not been lifted out of her cot all day; she was often very hungry and the bottles, which Jagat had prepared before work, were unused. It was not clear whether the baby had been genuinely neglected, or if this situation was simply a means of tormenting the young mother.

Finally Jagat was driven out by her in-laws. Even though they were ordinary working people, Jagat came to believe her in-laws were in a position to exert considerable influence over the law to take away her 24 month old daughter. The fact that they had set up an injunction to prevent Jagat from going to India with her child to visit her sick father confirmed this belief.

Jagat believed they could influence the social worker and her solicitor, invade the privacy of her own home and eventually deprive her of her child. As a result she regularly misinterpreted the actions and words of her social worker and even her solicitors almost to the point of alienation and lived in a state of high anxiety. After some weeks in therapy she began to be aware of some of her less productive survival strategies and tried to be more co-operative with the social worker. She also entered negotiations with her husband's family to attempt to curb the hostility between them.

focus of the work followed this regime:

- relaxation and stress relief
- constant reality checks
- getting the client to explore the actual likelihood of, for example, social services 'ganging up' with the husband's family against her; of husbands turning up to abduct their children; or of visitation rights being awarded to the husband, and legal rights reverting to his family.

There was a significant improvement in Samar's attitude after some weeks but the paranoia did not vanish altogether. It usually resurfaced heavily if there was a chance encounter with husband or in-laws or any communication from them. Women also felt the need to keep their addresses secret – in some cases, make their dwellings secure and somehow 'hide' themselves and their children. In Samar's case considerable work had to be done in therapy to get her to examine why she was willing to sign the papers to let her own very hostile parents adopt her son. It turned out that she believed her ex-husband was less likely to abduct her toddler from her parents than from her.

The feeling of being let down by the relevant authorities, a standard feature of the Battered Woman Syndrome/ Survivor Theory, was also very evident among our client group. Gogi, see Box 7, who had left her husband after an abusive, violent marriage, had to deal with the aftermath when her brother killed his wife. She was left to cope with the psychiatric services, the legal system, custody matters and fears for her niece and nephews' safety. Her troubles meant she found it hard to believe in the authorities.

BOX 6:

'Samar' would sit in the consulting room on the edge of her seat, frequently glancing at the drawn curtains. She would request the crack between the curtains be closed. She was hyper-vigilant every time she heard a car drive past, particularly if it had a roaring engine like that of a motorbike.

Samar had run away from her husband, whilst heavily pregnant. The immigration service confirmed he was on record as 'undesirable'. Currently living in Pakistan, and remarried with children, he had never been to England nor expressed interest in her son. Yet she was convinced he would turn up to try to abduct her son.

Her fears led her to leaving the boy with her own family despite their unpleasant treatment of her. Samar's delusions reduced substantially by the end of therapy and she made considerable progress. Sadly, she contacted SBS some months later to say she wished to resume therapy because her fears were returning.

Hostility and abuse from husband, in-laws and own families

Hostility and abuse from husbands, in-laws and own families was frequent. For example, in the case study in Box 8 below, 'Ananda' was abused by her husband; taunted and bullied by her in-laws. After she was physically ejected from the marital home they spread rumours that she left to take up with a former boyfriend. Her own parents set her up in slave-like conditions; her alternative was to return to her in-laws and a cruel husband. She now worries for her safety.

Some common examples of hostility and abuse experienced in the marital home where women also have immigration problems include:

- Passports, money and jewellery were confiscated on arrival.
- Confined to the house and not taken out, even to the doctor if unwell. If an emergency visit became necessary because a woman had attempted suicide, for example, she was always accompanied in order to ensure she could not report anything to the medical staff
- Constant persecution, such as being scolded or hit for clattering crockery while washing up, for causing a creaking noise on steps, for requesting to watch a particular TV programme, for answering the phone, for receiving visitors (even close relatives), having to cook to specific but very arbitrary standards e.g. the chapattis to be a certain shape or size; or pots and pans

BOX 7:

Although Gogi's brother had previously never been violent and adored his wife and family, he murdered his wife in an apparent schizophrenic psychotic attack. Later, he told Gogi that he 'received' whispered instructions to carry out the murder. As no evidence was identified on investigation of mental illness, she found no one would listen to her or help her secure psychiatric help for him.

During the trial, Gogi looked after her niece and nephews in her one-bedroom flat along with her own children. She fought for their custody but lost to the parents of their deceased mother, who had a larger house. The grandparents were hostile to Gogi. Despite the size of the house, the children slept on the living-room floor, or in a box-room; their clothes were stuffed into large bin-bags. She found the children ill-kempt and dirty when they visited, and it transpired that the grandfather had been beating her nephew and they were taunted as the children of a murderer.

Gogi had serious concerns for the children's safety. Her deceased sister-in-law had once told her that her father had sexually abused her when she was a child. Gogi felt she could not tell social workers her fears because her previous concerns about the children's schooling had been rebuffed.

When Gogi attended SBS, she was constantly on the verge of tears and suffered from periods of deep depression. Continuous back pain made her unable to work and made therapy sessions difficult. However Gogi displayed optimism, an indomitable sense of humour and demonstrated writing talent. Towards the end of her individual sessions, and in group sessions, Gogi had learned to deal more effectively with her relationships and regain a sense of herself and her own needs. Right to the end, she experienced a sense of rejection and refused help from the relevant authorities (e.g. the local council) even when her need was extreme.

to be scoured for 15 minutes, ban on using white goods, such as washing-machines, cookers, fridges or freezers, forbidden to watch TV or to sit with the family

- Constant mocking and belittling, such as being called a 'backward villager'
- Being generally ordered about and treated as a domestic servant, such as cooking and cleaning for the entire family while no other member of the family helped.
- Husbands frequently struck their wives for refusing sex even during illness or menstruation. In many cases. this led not merely to violent sexual assault but also sodomisation. One woman reported that in 19 years of marriage, she never once had non-violent sex. She was never given the opportunity to assent to or refuse her husband's sexual overtures.
- Constant threats that they would be returned to the family home and black-listed with the immigration authorities. Also, accused of having married only in order to receive British status and live here for commercial gain.

Immigration and asylum problems

Abandoned and abused wives

On the breakdown of their marriage, 'Renuka', 'Fatima', 'Romila' and several other clients were told by their in-laws that they would *'tell the Home Office to send you*

back', while their own parents instructed them to stay away from their homes in India. In some cases, their own parents told them in clear language, *'Don't come back here or you will be killed' or 'If you return we can't be responsible for what becomes of you';* or, *'If you are refused your stay in the UK, don't come back, do whatever is necessary to take care of things where you are'*. In two instances ('Rani' and 'Romila') this last remark triggered suicidal attempts.

The humiliation of a broken marriage (whether as the result of being driven out by abuse or being physically ejected or shut out of the marital home) is compounded by the terror of deportation to a society where these women have no chance of recovering from marital trauma or remaking their lives. Most women in this position seriously consider suicide to be preferable to returning home in disgrace.

In one case, 'Rani' (see Box 9) explained that after the breakdown of her marriage, her appeals to stay at home were rejected by her parents, and she attempted suicide. Initially her family had been confused and angry when her husband returned her to India four months after her marriage. A feud developed between her brothers and the family who had arranged the match. Gradually, proposals of marriage began afresh and she realised, thereafter, that she was considered not worth a good match:

Another client, 'Romila', described a similar situation before being sent away, *'I feel like something worthless, shunted from here to there. I'm like rubbish – no one wants me. It makes the loneliness unbearable.'*

Women, who had at different times been 'returned home' to their families

BOX 8:

Ananda was physically ejected from her marital home after months of being taunted by her mother-in-law. Her in-laws made excessive demands for jewellery or money. When Ananda returned to the marital home to collect her belongings, her in-laws told police that Ananda had intended to run away with her boyfriend, and had therefore removed her own clothes, jewellery and passport over time.

Ananda's accommodation in the UK had been organised by her immediate family in India to prevent her returning. She lived in a state of virtual slavery. Her parents insisted that she must endure it. The alternative would be to return to her husband who beat, raped and sodomised her and spoke to his girlfriend on the phone in front of her. Unable to pay her rent, she worked as cook, housekeeper, nanny and, unpaid, she redecorated the flat for rental for her builder-landlord.

Following the break-up of the marriage, her in-laws spread rumours that she ran away with another man. This allegation appeared in the divorce papers. Ananda had also become very fearful of a mysterious man who had turned up a few times inquiring about her whereabouts. She also became frightened when she saw her husband at a shopping mall, particularly when he caught her eye, turned away and made a telephone call. She was jumpy and tearful and unsure about what he intended to do to her.

BOX 9:

Rani said, 'I was in a state of despair realising what mayhem I was causing. And the proposals of marriage rammed home the fact that I was no longer considered worth a decent match. I had proposals from an alcoholic who had a wife and several children, a man who had no legs and another who was believed to have killed his first wife.

People brought these proposals without reluctance or apology and then tried to pressurise me, implying I wasn't in a position to choose. It appalled my parents too and made them feel so humiliated. It would have affected my sister's chances of marriage, so I sold my gold bangles, my father borrowed the rest of the money for an air ticket and sent me back.'

in India or Pakistan, experienced serious hostility from their birth families, including their siblings and, if their visas were still valid, were shunted back to Europe. Those women who contacted their families after leaving – or being expelled from – the marital home were variously threatened: pressurised to return to their husband and his family and warned not to come back to their birth family under any circumstances. In some cases, such as the case studies below (Box 10), women were enjoined to *'do whatever is necessary in the UK'* if they did not get leave to remain.

Asylum seekers

Women seeking asylum from a trauma in their country of origin, such as civil war, experience a sense of loss exacerbated by the ordeal of the official asylum procedures. They were often accused of attempting to defraud the system; in some cases they were told that they did not genuinely belong to their country of origin.

This accusation can be a profound psychological blow to an individual who has lost her home, and whose only link with it for the foreseeable future, is her national and cultural identity. An example of such loss was exemplified by the case of 'Naila' (Box 11) who arrived from Somalia in the middle of the civil war.

Homelessness, poverty, dislocation, cultural adaptation, lack of English and loss of self-worth were some of the problems prevalent among this client group. However, theirs were communities in exile with many shared problems and they could sometimes find support for immediate and pressing problems, such as isolation, translation of documents and interpretation at doctor's surgeries.

OUTCOMES

Boundary issues for the therapist

Working with women from these client groups was particularly complex because of their need for *practical* help where often all the therapist could offer was re-orientation. This complexity is shared by most psychotherapists working at resource centres where the work is primarily action and goal-focussed with a series of specialists or experts working for and behalf of the client. In such a setting, the client would

BOX 10:

- *'Fatima' was frightened and disoriented when she came to SBS; she was found wandering outside early in the morning, having been helped to escape her marital home by a neighbour. Fatima had been treated as a slave, imprisoned in the house, suffered 17 months of shocking physical and sexual violence from her husband. When SBS called her Pakistani parents, her mother instructed Fatima to return to her husband; her brother warned her that 'amongst people like us, women in your situation are put to death'. No one asked any questions about the women who disappeared in their village as it was a matter of honour. Fatima was placed in a short-term refuge; feeling no one wanted her and with the effective death threat from her brother, she attempted suicide. Subsequently following therapy and immigration support at SBS, she established excellent support systems within the refuge, and has now received leave to remain.*

- *'Meeta' was convinced that she would be murdered if she returned to her village in India. She believed her brothers and father would either beat her to death, burn her or lock her in a room and leave her to die of starvation. Rather than endure this, she had planned suicide by overdosing on pills or throwing herself in front of a train. Anxiety turned Meeta's hair white; during assessment, she either went off into reveries, or talked agitatedly. She said that the local police in India were of the same stock as her community and they would turn a blind eye to her family's cruelty. She would be seen as a corrupting influence on their sisters and daughters.*

- *'Samar', born and raised in London, returned home at 17 after a disastrous marriage in Pakistan. Though her parents had been settled in Britain for more than twenty years, they were still entrenched in community and heritage culture. They told her she was a disgrace, filled her with fear and superstition, and tormented her with the possibility of her son being snatched. Her siblings derided her for her failed marriage, for not contributing to household expenses and taught her little boy to disobey and insult her. The family encouraged the boy to treat Samar's mother as 'Mum'. The wider family got her remarried – a marriage she left. When Samar moved out to a council flat, her family continued to interfere: dropping by unexpectedly; and insisting that she lets out rooms to someone they suggested. They also kept her son insisting she pay them to support him. After nearly a year in therapy, despite some mental instability and a delusional tendency, Samar managed to get herself another property, and kept her whereabouts secret from her family. As she ended therapy, she was better settled.*

- *After some marital problems, 'Romila's' husband tricked her into returning to her parents, and disappeared at the airport, leaving her to travel alone. Romila was devastated by her husband's betrayal. When her family saw she was on her own, they immediately became hostile. 'There was only one thing on their mind…to get me out of there as fast as possible. I felt like a football being kicked from one place to another.' Romila now lives alone in a small room under difficult circumstances with fellow tenants. She has a part-time cleaning job. She suffers from isolation, insomnia, lethargy and depression. Her constant headaches and severe back pains are the legacy of beatings and sexual abuse by her husband.*

BOX 11:

Naila had lost at least two siblings, her father had been murdered whilst her mother watched, and then her mother and two younger siblings moved to a refugee camp. She was sent to the UK by a member of her employer's family, a man who had raped her since she was in her teens. The abuse had caused her severe problems as she had been given a pharaonic circumcision (infibulation) – the most severe form of female genital mutilation involving complete excision of the clitoris and sewing up of the vaginal orifice leaving an opening the size of a straw, so that even micturition becomes painful.

On arrival here, she was interviewed by immigration officials. She was exhausted, frightened and did not wish to relive her past experiences. When she had finished the interview report, she was barely capable of reading it through. She signed without checking it through, and later discovered discrepancies resulting from imprecise interpretation. Her application was refused on the grounds that the immigration authority did not believe she was truly Somali. 'They took away my identity from me. That was the only thing I still had. I felt there was nothing left'. A subsequent appeal was lost and her national asylum support (housing and financial support) taken away, so that she was cut adrift to live by any means she could. At assessment she was profoundly depressed, withdrawn and hopeless. She lived with an acquaintance in return for looking after her two small children, cooking and cleaning. She was sometimes fed, sometimes went for days without food, and was dependent on her friend's charity for basics like sanitary towels and toothpaste.

at first see the counsellor/therapist's work as oddly unfocussed and soft-focussed – simply one extra appointment on an already overloaded schedule and one more person who wanted to pick over painful and humiliating memories.

Clients often questioned the object of psychotherapy. One client, 'Anita' asked the therapist '*Are you going to be like a friend or confidante?'* and said that it was probably not necessary to come to the sessions anymore as she could not really afford the fare. The therapist suggested that she treat the sessions as an occasion to lighten the burden of grief that she carried.

There is generally food available at the SBS Centre and the therapist's instincts, often, were to feed Anita (and other women in her position); to give her money to help maintain her dignity; to do something about re-housing her. Instead, the therapist had to work hard to centre herself in subsequent sessions and worked instead on Anita's self-neglect following her days off in her new job. Careful exploration of her lowest points revealed a sense of powerlessness, inability to take control of her life and ignorance about such aspects of work as terms and conditions of employment. This made her dependent on others and she found that some men in the position of mentors were trying to take advantage of her situation. The overall aim of therapy was to achieve independence and the skills and knowledge to acquire such control. This included creating a list of daily tasks which included washing, eating, going for a walk to deal with her depression and isolation and learning to use public transport. Longer-term goals included learning English,

computer skills and driving. Within a short time, Anita had changed her appearance and taken significant strides towards achieving these goals. Positive feedback from interviewers on various courses and elsewhere had given her both confidence and pleasure and she was beginning to see possibilities in the future, though divorce proceedings and other issues continued to be painful.

In another example, SBS dealt with the complex case of Leela (see Box 12 below) which involved the need for practical as well as psychological help. She had been abused and defrauded of money in the UK and survived a three-year period in torture camp in her native Sri Lanka.

After several sessions of explosive frustration and anger, Leela began to talk about her unbearable living situation and her aggressive neighbours. Following several weeks of therapy, she was able to discuss her issues much more calmly. Her face grew more relaxed but she continues to be plagued with severe digestive problems and constant diarrhoea, Reynard's Phenomenon, and various aches and pains of varying degrees from arthritis and previous traumas. Her concentration span increased though she was often not able to sit through the full 50 minutes of a session and was often resistant to accepting help, as in the case of her housing. However, the Project worker took over in this area, helping her to resolve her housing needs and the process was speeded up considerably. The Project worker also helped her to reduce her debts.

Issues of the past, often more severe than practical issues in the present, are the *prima materia* of psychotherapy. Though this is especially challenging and harrowing, particularly in extreme cases such as Leela's, peer discussions, experience and a sound training combine to provide the tools to sustain the therapist while travelling with clients on their painful journeys into the sometimes hideous underworld of their past and its continuing impact on their present. However, it is the series of obstacles in the lives of clients in need of practical help and desperate for external support that present a profound dilemma for the therapist. As fellow humans and carers, therapists may feel impelled to move out of their role as mere therapists. The fundamental question is: how do you 'help' a woman to reflect on her anxieties, analyse her responses and make sensible choices when she is faced with losing her children; being deported to certain misery or even death; struggling with the horror of threatening neighbours, sleep deprivation, vengeful in-laws and persecution? The therapist is swung along on the emotional see-saw and often feels moved to take practical steps to remove or move along the obstacles that are so often the primary cause of the client's dilemma. Leela said in response to her GP's suggestion of anti-depressants – 'what depression? Separate me from my neighbour and the depression will go. I will stop being afraid and start sleeping.' Therapists have to remind themselves that this is at least, in part, a phantasy. To moot an instant solution would be simplistic – *reductio ad absurdum* since at least a percentage of the localised anxiety and distress can be put down to displacement on the client's part and as always, the point

of therapy is not for the therapist to resolve the problem, but to facilitate a resolution from the sufferer.

The therapist however, does feel de-skilled and impotent and will consider practical options such as ringing or writing to a medical practitioner, a social worker, or a refuge key-worker. Therapists have constantly to remind themselves that their job is to facilitate containment of the emotional issues. But this takes a concerted effort, and, often, with feelings of impotence and overwhelming counter-transference it takes the concentrated focus of re-grounding and a massive effort of will before they can consider how to return to the psychotherapeutic process within a session. The therapist identifies with the frustrations and helplessness of the client and their instinct is to deal with the frustration by picking up the phone to external authorities – needless to say it is essential to allow the feeling of helplessness to remain

BOX 12

When she arrived at SBS, 'Leela' was in freefall. She had been involved with a con-man, P, who defrauded her of her savings, and took out loans and ran up debts in her name until she confronted him. He locked her up in his box-room, drugged, beat and tortured her, stubbing out cigarette butts on her body, kicking and punching her until she was unconscious. Once he thought he had killed her and called an ambulance. However, P was never charged with these attacks.

Leela argued that she came to SBS to gain relief from her traumatic experiences, but she was secretly hoping to reinstate the investigation against P so that he could be punished for leaving her in debt and ill, and unable to work. She wanted to know how to deal with debts that totalled £80,000.

The Project Worker referred her immediately for therapy. Leela's first sessions were spent recounting her story in minute and confusing detail. Her face was contorted, she had various facial ticks, her manner was chaotic, and she carried a huge bag of papers, a blood-stained dress and other items she believed would substantiate her allegations against P. Her outpourings were torrential, her frustration over police mishandling of her case intense, her narration chaotic.

It transpired that Leela's past had much to do with her behaviour. In Sri Lanka, during her teens, Leela had witnessed the rape and murder of her sister by enemy soldiers. For two years Leela had been imprisoned in military camp, in a room full of the growing piles of bodies of raped, murdered girls, many still in school uniform. She, and the other prisoners, was expected to dig graves for them. They were raped and beaten regularly and kept naked in the room. They were tortured in similar ways to the way P had tortured her with beatings, cigarette stubs etc. When they were liberated by the Tamil Tigers, Leela wanted revenge but her parents sent her off to the US for asylum. She missed her connection from Heathrow and ended up in London. In due course she received asylum in the UK.

within the room and to deal with the internal, rather than to divert attention elsewhere or to open up the therapeutic container to the external world and thus lose the opportunity to process the helplessness by temporarily achieving a sense of control. One way of dealing with this is to refer certain issues back to the client's case worker. However, if such external consultation is deemed necessary it is essential this should be done after the session, having received the client's permission. This is usually a reassuring first step and an immediate crisis response to the client but coming at the end of the session it does not disrupt the actual work at hand which is the ability to process and find ways of dealing with the actual therapeutic issue: feelings of disempowerment and worthlessness. This often worked well in the Project.

For the therapist, all the SBS client groups present an interesting area for exploration of boundaries. Since the most urgent focus of such clients is, naturally, on externals and they believe that all would be well if their external problems were resolved, be they related to asylum/leave to remain, amicable settlement of child-related issues, divorce and other problems such as homelessness or poverty, connected with the ruptured marital situation. Amazingly, a large number of women would seriously consider reconciliation and a return to the marital home despite a catalogue of cruelty and humiliation, though some, after a few weeks of therapy, do become aware, reluctantly, that they have freedom of choice and that it is not necessary to always let their lives be dictated by others. They understand, therefore, that should an offer of reconciliation be extended, they would insist on certain conditions from their husbands. Others would be willing to return only if the husband moved out of the extended family home (i.e. his parents' house).

The boundary issue here is that the therapist may often experience a counter-transferential sense of floundering, helplessness and loss of direction. The first impulse is to recover a level of control by taking some kind of action – generally, in the first instance, to get involved in providing practical assistance by writing to relevant authorities or speaking to a doctor although these issues were being addressed by the caseworker. Examples of projective identification include carrying the clients' inexpressible rage against society in general and their husbands and families in particular. Thus the therapist needs to be brought back to the essence of her own function, which is to facilitate self-awareness, the availability of choice (though in such circumstances, it is often very hard to posit this) and the strengthening of the client's inner resources and available options to balance the uncertainty surrounding external needs or desires – reconciliation, divorce, custody of children, leave to remain.

Outcome of therapeutic interventions

Method

The simple method of evaluation outlined below seems to indicate that, on the whole, clients benefited from therapy if only by becoming more self-aware and attending to the basic demands of daily life.

Below is a 'checklist' for the first weeks of therapy following assessment. The second half, 'endings', was completed during the final 3-4 sessions of therapy after the client's progress had been evaluated through a careful review of the notes (the 'endings' section below has been completed as an example and reflects outcomes in the case of an actual client assisted in the therapy). Roughly one third of each of these final sessions was spent on discussing the areas in which the client had progressed, how she felt about it and substantial or significant benefits of this. During this process the client had time to fully assess her own development and to acknowledge her success and areas where more work was needed. She could also pinpoint where she would like to make further progress and devise strategies to do so.

Using the 'checklist' as a reference, the therapist assessed with the client the progress that had been made by the end of therapy. Frequently, the majority of the problems had been addressed and overcome to some degree. Final results or 'endings' included the following:

- Standing on their own feet. Moving towards independence — travelling, communicating in English, finding accommodation, changing accommodation, finding work, dealing with professionals, e.g. lawyers, etc.
- Taking care of themselves, eating better and changing their attitude to money
- From apathetic, scared and withdrawn, to becoming active and taking basic responsibilities for themselves, such as negotiating time off with a difficult human resources department.
- From being obsessed about their anxieties re: deportation, homelessness, gossip, to becoming pro-active, focusing on what they can do now and to make the best of the time they have here and/or finding a place (e.g. sessions) to put their overriding anxiety, like deportation.

Checklist	
At Assessment	***Endings***
Disoriented	More alert and settled
Overwhelmed, disempowered, unable to imagine the future	Lonely but beginning to appreciate aspects of independence
Victim feelings	Rare, but still recalls, healthily, how she felt
Depression	Improved
Anger, mostly suppressed	Beginning to express anger – at times misdirected
Feelings of intense shame and humiliation	Much improved
Fear of ridicule	Less than before
Complex of obsessive fears	
Deportation	Deals with it by avoidance
Being tracked down and killed	Occasional hyper-arousal
Gossip	Reduced fear of gossip
Financial anxiety	Looking for a job
Homelessness/dislocation	Loneliness still extreme (unable to trust enough to make friends.)
Suicidal feelings	No suicidal ideation – though does say she will kill herself if refused her stay
Helplessness in practical matters	
Can't get around	Travelling freely and confidently
Can't speak English	Just enough to get around but still lacks confidence
Can't initiate or progress simple necessities e.g. open account	Has tried opening an account – awaiting solicitor's letter
Find out about jobs, get insurance cards etc.	Trying through friends and Job Centre – difficult as no NI card as yet
Inadequate diet	Improved
Withdrawn and afraid to communicate	No but lack of knowledge of system and rules was daunting
Physical symptoms	
Insomnia	Only occasional
Dizziness	Rare
Headaches	Better
Stomach problems	Better
Lack of concentration	Alert
Loss of appetite	Eats better

- Realising the emotional and psychological benefits of being out of the abusive environment.
- Learning that choice was available to them and that choice is not simply a selection procedure but applies in all areas of living – they learnt they could choose to feel a particular way or choose to react in a particular way. By adopting and practising this attitude, often they had been able to work back and analyse their attitudes to e.g. gossip, disgrace, abuse in a different way. Thus they began to overcome limiting beliefs which was a huge benefit when dealing with gossip or the paranoia about it.
- Developing honest relationships, being open and considering the notion of true friendship.
- Developing assertiveness vs. 'acting out' (e.g. having a tantrum or withdrawing in a given situation instead of simply stating that the situation is causing them upset.)

A significant, additional problem was the matter of loss of status. Many of these women were well-educated and came from respectable families or had careers before being married and coming to the UK where they were first broken down by their husband and his family. Loss of marital status was accompanied by more reduced circumstances, homelessness, poverty, menial jobs such as cleaning, or working on a factory conveyor belt where they felt they were treated like automatons working to draconian rules and regulations. The therapy 'ending' assessed how successfully they coped with these problems and how motivated they felt to change their social situation.

MANAGEMENT/TREATMENT

The management of clients referred to the SBS therapy service fell into three phases, generally, though not necessarily, in the following order:

Functional care

Much of the earliest sessions was devoted to letting the client pour out her story or encouraging her disclosure [10] through her unease and embarrassment by putting questions to her from the Assessment Questionnaire.

The Assessment Questionnaire relating to the client's physical and mental condition revealed that self-neglect was invariably a primary consideration. Though physically well-presented because of the honour issue, these clients tended to ignore physical symptoms such as dizziness and chronic headaches, occasional bowel problems and insomnia. They justified self-neglect on the grounds that it was the inevitable consequence of their emotional and phenomenological state. Clients were set short-term goals, such as a visit to the GP or a daily plan which included getting out of bed, showering and taking a walk, or ensuring three balanced meals a day. In one case, a client had failed to go to hospital for a blood test for anaemia. On questioning, it emerged that she was reluctant because she did not speak sufficient English. The Project worker arranged for her caseworker to accompany her. She was grateful but felt guilty for having 'exploited' SBS resources. The guilt issue was clearly the effect of acute low self-esteem.

This boundary overlap, regarding practical issues (mainly self-neglect), has been a marked feature of the work at SBS without having an adverse effect on the quality or process of the therapy. The 'advisory' function has included discussions on:

- nutrition
- use of relaxation techniques to aid sleep and to process trigger reactions
- strategies to fend off intrusive questions from family, acquaintances or strangers in the temple and other meetings

For example, in the case study below, 'Shashi', feeling overwhelmed by her medical and legal commitments as well as duties to her children came into every SBS session saying she was 'a mess' and did not seem to be progressing.

Cognitive work

Identifying areas of emotional dysfunction, self-image or difficult behaviours and finding strategies to transform these, recognise the triggers or cope with these tended to be the second stage of the therapy.

By the third week, the client had usually managed to express a considerable part of her pent-up frustration and emotions in therapy sessions. She was also beginning to find some sense of relief and empowerment in taking a little more care of herself. The therapy is generally humanistic and person-centred, and clients tended to use it to re-run the traumatic experience and the crisis which had brought them into therapy. The recent past was addressed as were current concerns and anxieties. Rarely, a specific resistance would require delving into the childhood/subconscious. However it has not been necessary or in many cases even possible, in terms of the short and multi-phased therapy, to engage in in-depth analysis.

Cognitive work tended to begin in the third week to provide some focus for the client and divert her from the areas of anxiety which are entirely out of her control. This has included working with phobias and delusions, reality checking, (one client often referred to *'he (her husband) and other people following and listening'*) working on strategies to manage depression, to become creative (very much helped by various SBS support incentives with writing and photographic workshops and residentials) and to begin to symbolise and look into the future. This has brought tangible results and focused the women on their current situation – survival – and hopes, plans and strategies for the short-term future.

BOX 13

'Shashi' revealed she felt overwhelmed by her obligations to her friends: living near the park, they would drop in on weekends and holidays. Unable to turn them away, because these were the people who had supported her through her bad time, she was exhausted by their presence. In therapy, time was spent developing various strategies with Shashi who was able to employ them in the short-term. Subsequently she reverted to her old habits, primarily because she was desperate to be liked in spite of being a divorced woman.

Analytic work

In the third phase of therapy, generally around the 15th-20th session, women came to a point where they were able to look analytically at ways in which to combat their inner conflict, sense of loss, fear of the future, antipathy to men and marriage, while awaiting the outcome of solutions to their external struggle. For example, Shashi, (see Box 14) who had reverted to allowing visitors even though they oppressed her, contemplated getting a part-time job. This fulfilled the need to distance herself from her visitors, get out, and engage with the future.

BOX 14:

Shashi made an appointment with a careers advisor. She had no immigration problems and had solid work experience behind her, although trauma left her with severe spinal and dental injuries which will require continuous treatment for the foreseeable future. A primary (and conscious) aim in finding work, was 'to get away from the house' to avoid unwelcome visitors. A secondary aim was to have something to occupy her mind while she waited for the slow divorce process to be concluded. The third aim, to build a future, was particularly encouraging because it showed that Shashi had begun to engage with the future and was taking the first steps to take some responsibility for it.

REFINEMENT OF THE HYBRID MODEL

From 2005 to 2006, the therapist refined the use of standard therapeutic techniques and experimented with some of the directional elements drawn from Life Coaching, such as the introduction of small, timed targets building up to a major goal, as well as the utilisation of more stress-relief techniques.

It was noted during the first few weeks of a client's therapy when the 'checklist' was still in the process of completion that a number of young, Asian clients in the intake appeared to be responding to the therapeutic process at a faster rate than previous clients, usually within the first three weeks. They moved swiftly from a distraught, hapless and disoriented state to a much more sustained psychological position where they were able to see their predicament more realistically and move away from the initial sense of victimisation and the conviction that their life had 'ended' or been 'destroyed', which is their usual terminology.

They appeared more conscious of their independence, of the possibilities ahead and the importance of self-reliance. This is not to say that they no longer suffered from a sense of loss, dislocation, humiliation, acute loneliness, continued loss of appetite and depression, or that their physical symptoms such as headaches or insomnia had disappeared. It was more a case of appearing to recognise the value of a positive and proactive attitude which would put the usual anxieties in perspective. They became more animated, laughed and joked more, spoke more openly and perhaps, most surprisingly, for such a group, they began to make friends with other users and share experiences. It was noted by staff that on several occasions, they shared yoga, stress

relief techniques and nutritional advice learned from television and/or therapy sessions, in the kitchen and reception. All the above have, very likely, contributed to the swift progress on subjects under discussion in these activities, in much the same way as in self-help groups. Inevitably there are implications for confidentiality, especially when one client may mention another in a therapy session but this was handled with a gentle reminder about confidentiality.

It appears that certain techniques, tried out as the result of reviewing and reflecting upon classic analytic/therapeutic methods which did not work as well in the short-term, appear to have been effective in conjunction with the new methods. Many of these were formulated on the basis of long-term work and a gradual process of absorption and self-understanding among a largely white clientele with a European based value system. Others are more cognitive techniques requiring a proactive and involved approach. Examples of the latter may include goals and tasks for 'homework', such as keeping diaries, making lists of limiting beliefs, triggers for symptoms/panic attacks, causes of depression among others. 'Thought flooding' is one such method, where the client is asked to reflect on specific anxiety-inducing scenarios at a regular time each day for a specified time. The aim is to desensitise the client from the negative effect through repetition, to reduce the worry and finally, to contain and confine the anxiety to particular times.

In the case of the SBS client group, such a strategy was counter-productive: the women constantly obsessed about the anxiety of deportation and the 'death-row' mind-set underlying the decision of whether they would get leave to remain or not. The 'unnamed dread' was the ultimate disgrace of being forced back to the parental home because of a broken marriage and it was of such magnitude that it could result in the client's fratricide or suicide. In the event, they considered the latter less terrifying because they had some control over it. But most women confessed that this was the option of last resort.

It has helped these clients to go over the traumatic event in greater detail in the safety of the therapeutic container, allowing memories to resurface, fill out and be relived from the present and to introduce, each time, some questions to challenge the apparently inexplicable desire to continue the marriage and reconciliation. By a continuous but gentle process of asking 'what if…you were still there? You go back? You were still enduring the trauma? How would your husband/in-laws treat you should you return? Would there be retaliation? Would they let bygones be bygones? Would they recognise their mistakes/cruelties and change their ways? The answers to all these questions changed gradually from non-committal, such as, 'well, that's where I've got to live' or 'I guess some of the fault could have been mine,' to more realistic responses, such as 'I don't think I could bear it', 'I'd go back if…' to an outright 'No. Never, not now.' This then released the client to look more clearly at the future… 'it's going to be hard on my own.' ,'How am I going to get on?', 'My family will never forgive me/

take me back,' 'I don't ever want to return to my parents'. In the wake of this, women were able to express some anger towards parents, society and husbands. Finally came the realisation that their life, with all its pitfalls, terrors and possibilities, could to a large extent, be moderated by their own determination and vision. As most of the clients had immigration problems, over all this loomed the spectre of deportation which quickly revived feelings of dejection and an overwhelming sense of impotence but the wonder of having some power over their own lives, of reaching out and taking what they could because they no longer had anything to lose, was exciting and highly motivating. This was a labile stage for the clients: the existential anxieties of self-worth (or lack of it) immediately came into play while finding work, learning to negotiate the system and its requirements such as work permits, finding work and opening bank accounts.

Having discussed their set of goals in therapy sessions, clients received full support and advice from SBS caseworkers but started to become embroiled in matters of daily life and its demands; for women with immigration problems, their anxieties about leave to remain found its own place, resurfacing heavily as they went to bed, if they woke up in the night and when other triggers came into play. Triggers included necessary activities such as making statements to solicitors, divorce suits either from the husband or initiated by themselves (always a cause of deep distress and painful memories of lost hopes). However, most learnt to use the sessions well to deal with triggers. Disorientation and apathy would sometimes return but were tempered by the demands of daily life.

It was from this point that space was found in each session for reflection on all the elements of life on which the client did have reasonable power and control and those areas, such as the outcome of their asylum/ immigration applications, over which they did not. All clients at this stage managed to live productively and have spells in which they could interact, communicate and live functional lives, though distress, grief and fear were ongoing and underpinned their lives to varying degrees.

Bearing all this in mind, analysis of the evolving therapeutic techniques revealed a mixture of the standard therapeutic processes of empathy, a confidential and safe space for listening, congruence and the ability to demonstrate lack of judgement or blame, and belief in the client's suffering. It also included mirroring, reflecting back and gently but increasingly challenging the client's social conditioning.

Life coaching

Having noted the paralysing effect of anxieties inculcated by social conditioning which shattered the motivation and self-belief of clients and bearing in mind the maximum of 26 weeks of therapy, certain techniques from Life Coaching were introduced with the aim of dispelling, or at least bringing into perspective, such limiting beliefs.

First, this meant pinpointing areas of optimum stress. These broke down into:

- Times – bedtime, going out, meetings

with solicitors etc.

- Triggers – fear of outcomes; thoughts of future; unnamed/unmentionable results
- Manifestations of triggers – headaches, insomnia, tiredness, depression, panic attacks, agoraphobia.

Unsurprisingly, a primary area which emerged was around social attitudes concerning divorced/abandoned women, stigma and cultural paranoia, fear of being tracked down and 'punished' or killed. The method used to slowly begin the process of shifting preconceived ideas about women in Asian society was task-based and goal-oriented.

Anchoring/switching

This technique required the client to focus on an optimum moment or experience and then 'clench' their fist. In moments of stress or flooding, the client simply clenched her fist to recall the positive memory and rise above the stress. This required regular practice. Box 15 illustrates the effectiveness of this technique in the case of 'Shalini', who used it during acrimonious discussions with siblings in India, following her mother's death. Although not her fault, her marriage break-up was seen as the cause for the death.

Away from pain towards pleasure

This technique takes into consideration the traumatic event and all its attendant anxieties and grief and attempts to facilitate reflection on what might be desirable in future.

BOX 15

Shalini was able, first, to use anchoring to restore her equilibrium during and after such discussions. She then used other techniques to assess objectively if she could reasonably be blamed for her mother's death from terminal cancer. These coping strategies were reinforced in therapy sessions.

Uncertainty

The desperate attempt to feel certain is profoundly disempowering. When clients arrived at SBS or into therapy they felt, above all, terrified of their helplessness as they were usually entirely without resources and had to depend on others for basics such as food, shelter and access to help. This could create different kinds of behaviour: demanding, aggressive, excessively withdrawn, tearful, inarticulate or overwhelmed but usually in the case of SBS clients the latter four listed above. The crisis they experienced and the likely outcome of their broken marriage had made them feel completely out of control. Often they had never had to look after themselves and the prospect of surviving in a world made hostile by threats and the dangers created by lack of familiarity with the environment, the language, the system, the host culture or the projected hostility of their own diaspora communities, caused them to create a frightening vision based on interpretation rather than real events. The certainty of a negative outcome seemed somehow to confer a greater level of control than the terror of uncertainty, even if the latter consisted of a possibly positive result.

The method used in therapy to combat this was to focus on:

a) the here and now
b) coping resources and strategies
c) desired outcomes.

Clients were encouraged to develop exercises for this during therapy sessions and afterwards. They thus focussed on what they *could* achieve and on taking steps to achieve it and to try first to take the focus away from that which they could not control and eventually, to let it go.

The 'unnamed dread'

Death – as a result of murder or suicide, either by their abuser or as a result of their own desperate act of self-harm, which is often assumed to be a consequence of their fate or kismet – was often the underlying fear. The work here entailed developing a sense of perspective. Death is not predictable in any circumstances, so why try to predict it? Discussions about death or modes of death likely to be inflicted by relatives or self were openly discussed and then left behind. Often, too, there were discussions about the afterlife, particularly for those with a suicidal ideation. This tended to be a religious client group and notions of an afterlife, redemption and retribution were very real to them. Clients found obvious relief in having named these anxieties though, naturally, there was also much pain and fear, especially in the initial phases of the exploration.

Coping strategies

Often, the single most effective line in response to the client's fear of 'not coping' with her situation, was to point out that she has coped. This generally brought about an instant awareness followed by brainstorming a list of 'successful' incidents. The client began to acknowledge that she had survived and slowly started to deal with the complex process of embracing responsibility and leaving behind, often, a lifetime of control by her family and society. The comfort of depressive illness or ignorance and apathy was often terrifying to relinquish but it was quite startling, at times, how women took to it and went from strength to strength.

Insomnia

A cognitive approach was generally adopted here. The client was told about the process in motion here and given relaxation techniques. They were generally taken through a creative visualisation in which they imagined a favourite colour and filled their minds and bodies with it; to increase focus away from niggling anxieties into a calm, still state, they were encouraged to fill out the colour with detailed patterns or transform it into intricate shapes or to employ the standard technique of relaxing the body, toes up, section by section. The other common technique, of meditating on a pleasant memory or a favourite or ideal location did not appear to work as well when clients were on their own, as it did in sessions, where their increasingly relaxed state was clear from their facial expressions and body language. However, clients reported that the

first two methods worked admirably when they used them on their own. The challenge was to form a habit of using them regularly.

Severe headaches

If the doctor had found no physical cause for severe headaches, then the following simple exercises were recommended:

- breathing techniques
- going for a short walk
- drinking water
- checking on food intake in the last 48 hours
- lying down in a darkened room

Transforming the negative

When negative thoughts were articulated or inferred during a session, an attempt was made to transform these into a positive declaration.

Examples included the following:

- I'll never get over this experience' TO 'It will be hard but at least I'm not being humiliated and beaten every day. I can do it.'
- 'I'll never belong again. I'm an outcast' TO 'It is better to build a new, independent life according to my own values.'
- 'I'm only 22 and my life has been destroyed' TO 'I'm still young, I have a lifetime to make the life I want.'
- 'They must have laughed behind my back' TO 'I don't need to worry about them anymore. They're out of my life.'
- 'I'll never trust a man again' TO 'All men are not like my husband – I've seen kind husbands.'
- 'I'll never marry again' TO 'I'll become an independent woman and then I can decide what I want to do with my life.'
- 'Why did they throw me out when I was willing to endure everything?' TO 'Thank goodness I'm free from the abuse. It'll be tough but I'd never have left of my own accord.'

Self-blame

Women would often make the following comments: 'Perhaps I shouldn't have called the police'; 'maybe I did something wrong'; 'I'm the cause of my family's humiliation and dishonour'; 'I've disgraced the people I love most'.

Much of this was mediated by social concern and, when challenged, women would often respond that it did not matter whether or not they contributed to the abuse, the important issue is that society blames the woman. When asked honestly what they believe could be their mistakes, they admitted quite quickly that they had agonised over this and could not come up with anything significant. So desperately did they go over all the ground that they occasionally resorted to illogical answers – one woman believed she had upset them by pushing in the button on the cooker so hard that it broke.

Core beliefs

One of the most persistent areas of limiting belief remains that of challenging *core beliefs* which in this client group tended to be *collective* and built upon centuries of cultural and religious indoctrination in all

communities. Challenging these embedded beliefs in favour of *individual* expression or *personal choice* automatically discredited a woman so that she was instantly placed outside society. She therefore had to have the courage not merely to take on the force of social censure but to do so without the support of her family who must naturally uphold religio-social mores in order to retain some kind of social status.

A combination of the above strategies did help women to become more familiar with the concept of individual rights and at the same time accept the painful knowledge that while they may live by those rules in the UK, they would instantly fall foul of them in their home country. Thus the desperation to receive leave to remain became all the more pressing. Their life depended on remaining in the UK.

CONCLUSION

In conclusion, while the group work used the tried-and-tested 'Skilled Helper' model with a few adjustments to help trust and disclosure within the group – the individual therapy led to the development of a new hybrid model making use of standard, classical techniques with new ones, such as those derived from Life Coaching, with the aim of meeting the specific needs of BME, particularly South Asian, women who had experienced domestic violence.

The success of the Skilled Helper model and the new hybrid model are illustrated by the following case example of Gurinder, who came from the Punjab as a high status university professor but in London lost all status and was kept in fear by her husband and his family. The SBS therapy meant she was able to gain self-esteem and take control of her life:

BOX 16

Gurinder was a university professor in the Punjab and consequently held in the high esteem accorded to the teaching profession in the sub-continent. She was also highly regarded because she had never been associated with a man before marriage, and her personal conduct had never prompted gossip. Thus she was expected to make an excellent match and to live a life in which she would continue, or improve, her status.

Once in London, however, she was put into a flat with her sister-in-law, whilst her husband lived with his mistress. Her sister-in-law and husband assaulted her, and her brother-in-law attempted to rape her. She was locked into her room, forbidden to touch the television or use the toaster or kettle and eventually even to cook. She would eat one meal at the temple and never have more than £2 to spend on a meal. She endured the situation as she was terrified that she would become homeless if she vacated the flat.

By the time Gurinder completed therapy, (28 weeks one-to-one, followed by 26 weeks in the group) she had become much more independent and taken full control of her life.

While there were few unsuccessful cases (mainly because these cases were complicated by clients having alcohol misuse problems or severe clinical depression), the majority were successful. Indeed, an analysis of the outcomes in counselling showed a 94 per cent success rate for the period from 1 April 2002 to 31 March 2006 when a

total of 50 clients were assisted. Successful outcomes were measured by improved levels of functionality, and reduced reliance on medication and levels of depression and self-harming behaviour.

UPDATE

Between 1 April 2006 to 30 September 2009, counselling was provided to an additional 34 women. These women were predominantly South Asian, and younger; there were more women from African and Caribbean backgrounds from June 2008 onwards.

The patient profile and content of counselling sessions remained very much the same as before. Women were suffering from the effects of domestic violence in which their trauma was complicated by the attendant fear of pursuit and vengeance by their husbands and in-laws as well as profound anxiety that they could be removed from the UK.

By June 2009, six out of seven clients were aged 15-23 years of age, with a greater number of pregnancies or small babies. These women appeared to have suffered more acute levels of cruelty than those reported by previous clients, which appeared to be linked to vulnerabilities produced by their youth, immigration status, close extended family units and poor backgrounds. These included experiences of starvation and incarceration with women being tied, gagged, locked into conservatories and garages, scalded, burnt, beaten and raped. They were also deprived of sleep and denied regular use of the lavatory and forced to drink out of the lavatory taps instead of drinking water. A high level of emotional and mental torture was also often involved, including women being forced to malign their families and confess to false allegations in public. One woman was forced to flush her miscarried foetus down the toilet instead of giving it a burial and still carried the guilt and fear of committing a heinous and sinful act. A number of women were told by their husband and in-laws that they would not be allowed to become pregnant and indeed, when they did become pregnant, they were forced to have abortions.

Two of the women were 15 years old. One had given birth to a child of mixed Caribbean and English parentage, while another was a Grenadian, who had been abandoned by her parents when she was nine years old. Extended counselling was also needed by a Kenyan client seeking asylum. She had refused to participate in tribal sex rituals in Kenya on religious grounds as she was a 'born again' Christian, and because of her fear of being contaminated by her husband who had an affair with a woman who had died of AIDS. She had also received threats to her life for her work against female genital mutilation. When her marriage ended, her house was burnt down and her children dispersed. She was anxious about her children and fearful of being deported.

The 'hybrid' model was used in the counselling and psychotherapy sessions, and its effectiveness is illustrated by a 96 per cent success rate in women feeling less depressed with greater self-esteem and functionality, and reduced levels of medication and self-harm.

CHAPTER THREE

Addressing and Preventing Suicide and Self-Harm

Suicide and self-harm are key issues which arise repeatedly in enquiries and cases handled by our Domestic Violence and Mental Health Project. Most women report having contemplated suicide at least once in their lives, and many have attempted suicide or self-harmed. In a few cases, this has involved tragic deaths as a result of suicide. Over a period of thirty years, we have dealt with 18 suicides or deaths due to unknown causes. A frequently asked question is why women feel they have no option but to kill themselves. When asked, women or the deceased's relatives or friends often talk of abusive and oppressive practices within the family. These include domestic and sexual violence, forced marriage and restrictions over lifestyles underpinned by use of male power to control women's autonomy and sexuality, and often justified by religious and cultural notions of shame and honour.

NATURE AND EXTENT

Research has also found that Asian women, particularly those aged between 15-34, are up to three times more likely to kill themselves than women in the general population. These findings are consistently repeated over three decades in the 70s, 80s and 90s (Raleigh, 1996).[1] In one study in West London, which included women who approached Ealing hospital, Asian women had the highest overall rate of attempted suicide: 1.6 times those of white women and 2.5 times the rate of Asian men. For young Asian women (under 30), the rates were 2.5 times those of white women and 7 times those of Asian men (Bhugra et al, 1999).[2] Another study found that young Asian women (16-24) had a 1.5 fold risk compared to white women in the same group; Asian women were also over five times more likely to self-harm than Asian men (Cooper et al, 2006). Studies have shown that the rate of suicide ideation is higher for Asian women compared to UK-born women, and three times the rate of Asian men (Merrill, 1990; Merrill & Owen, 1986).[3]

This research showed that, in most cases, the high rate of suicide and self-harm was not associated with a history of psychiatric disorders, but rather indicated that social factors, including abusive and oppressive practices in the family, were the causal factors. This has been confirmed by a number of qualitative studies. (Chew-Graham et al, 2002; Chantler et al, 2001; Bhardwaj, 2001; Muralidharan, 2007)[4]. International studies also indicate a higher rate of suicide and self-harm amongst South Asian women in the Indian sub-continent and amongst the South Asian diaspora, where rigid gender roles and abusive practices are recognised as the cause.[5]

Before the Suicide Act 1961, suicide was a crime. However, suicide still carries considerable social stigma, and some religious beliefs regard it as a sin. Therefore, cases of suicide and self-harm may be a hidden problem in many communities. The problem has been increasingly recognised by government, mental health and domestic violence agencies. [6] In 1999, the Government set a target to reduce suicide by at least

20 per cent by 2010 in the White Paper *Saving Lives: Our Healthier Nation*[7] which was reinforced by the *National Service Framework for Mental Health*.[8] Methods for tackling the problem are outlined in the *National Suicide Prevention Strategy for England*.[9] These recognise the need to tackle the disproportionate rates of suicide among South Asian women. However, by 2008, while there was a reduction by 20 per cent in overall levels of suicide,[10] it is uncertain if this also true for Asian women. In fact, although disputed by one study[11], most studies indicate that suicide rates continue to be disproportionate for South Asian women

The SBS Domestic Violence and Mental Health Project aims to reduce the incidence of suicide and self-harm amongst BME women subjected to domestic violence. SBS has used its experiences and research to inform policy and campaigning work by arguing that suicide, attempted suicide and self-harm can be a cry for help, a coping or survival strategy, or a final act of desperation caused by or contributed to by domestic violence. This has resulted in demands for more resources and improved services to deal with domestic violence within BME communities in order to tackle the problem (see chapter 4). In particular, and somewhat uniquely, SBS has attempted to highlight the link between domestic violence and suicide in the Coroners' courts when Asian women have committed suicide or died in suspicious circumstances, in order to prevent future fatalities. We recognise that, as one agency said in our consultation exercise (see appendix 2), *'Suicide is the tip of the iceberg – for every woman that succeeds in killing herself, there are many more in need of help'.*

ATTEMPTED/CONTEMPLATED SUICIDE AND SELF-HARM – THE SBS SAMPLE

Suicide is a sign of despair where there is no will to live, but some may be acts of self-harm gone wrong. The distinction often lies in intention rather than results. Self-harm is not always intended as a suicide attempt, but self-harm can increase the likelihood of a successful suicide. Many attempted suicides and acts of deliberate self-harm, such as cutting and eating disorders, are a cry for help and a desire for a better life rather than death. Often these are coping or survival strategies used by women to release tension, escape pressure, protest and/or exercise control over their lives. Others, however, also regard their actions as inevitable, and are resigned to their fate, destiny or kismet, particularly if they want to prevent shame and dishonour (see, for instant, the case of 'Yasmin' in box 3).

Imrana Afzal, an SBS client, had escaped a forced marriage in Pakistan, and explained why she self-harmed [12].

'I slit my wrist as a protest. I slit my wrist on 14 August which is the day of Independence for both India and Pakistan after the British Raj, as a protest to illustrate that is what you actually are expecting me to do. To say I am made of flesh and I am made of blood, and I do bleed and this is hurting me. And you say you want my happiness, but this is not conducive to my happiness at all.'

But others, like 'Gurpreet' say *'I felt that my life had been ruined and that I had nothing left to live for.'*

Incidence

Many of the women who contact SBS have contemplated or attempted suicide or self-harmed at least once in their lives. A small sample (12 per cent) of 409 SBS women from April 2001 to March 2009 (see chapter 1 for more detailed analysis of this sample) highlights these issues.

The following is a breakdown of contemplated and attempted suicide and self-harm in the sample group (where known):

Table A: breakdown of contemplated/ attempted suicide within SBS sample group (12 per cent of total number of women seen)

Year	Contemplated	Attempted
2001/2	8	5
2002/3	10	6
2003/4	13	4
2004/5	32	13
2005/6	31	12
2006/7	34	16
2007/8	28	10
2008/9	23	7
Total	**179**	**73**
Overall total	**252**	

Findings:

- 62 per cent of the sample group contemplated or attempted suicide and self-harm.
- 44 per cent of the sample group contemplated suicide and self-harm and 18 per cent attempted or went on to attempt suicide or self-harm (multiple attempts have not been included).

Methods

Methods contemplated or attempted for suicide or self-harm by the sample group (where known) are shown in Table B, p69

Although there is insufficient research into why women use particular methods, it may be the case that some Asian women, who use fire, are influenced by popular cultural notions which cut across religious groups but are derived from the story of Sita who submits to the test of fire to prove her sexual purity to Rama in Hindu mythology. Some methods may be used because of accessibility. For example, kerosene is likely to be used in the Indian sub-continent, where it is more widely available, while tablets are more readily accessible in the UK.

Table B: Breakdown of methods of contemplated/attempted suicide within SBS sample group

Year	Method	Contemplated	Attempted
2001/2	Cutting[1]	1	2
	Overdose[2]	2	2
2002/3	Cutting	3	
	Jumping[3]	1	2
	Overdose	3	5
	Burning		1
2003/4	Cutting	4	2
	Jumping	1	
	Overdose	3	
	Burning		2
2004/5	Cutting	1	8
	Overdose		5
	Eating disorder		2
	Shooting	2	
2005/6	Overdose	3	4
	Cutting	1	1
	Jumping		3
	Hanging		1
	Burning	1	
	Eating disorder		1
2006/7	Overdose	5	9
	Jumping	2	3
	Cutting		1
	Burning		1
	Hanging	1	
2007/8	Overdose	3	7
	Jumping	4	
2008/9	Overdose	4	2
	Cutting	2	1
	Burning		1
	Hunger strike		1
Total		**47**	**67**
Overall total	**114**		

1 Cutting includes piercing with sharp objects such as needles and knives.
2 Overdose includes self-poisoning e.g. taking tablets or other substance such as bleach or fertiliser
3 Jumping includes from a height or in front of a vehicle, such as a train

Findings:

- 45 per cent of the women known to have contemplated or attempted suicide used the above known methods at least once (multiple attempts have not been included).
- The most common methods of attempted suicide or self-harm, contemplated or attempted were cutting and overdosing, usually with tablets (75 per cent).

Age

The age of the sample group who contemplated or attempted suicide and self-harm (where known) is shown in Table C

Table C: breakdown by age, SBS sample group

Year	16-25	26-36	37-47	48-67
2001/2	4	1	1	
2002/3	5	4	1	1
2003/4	3	4	1	2
2004/5	12	8	2	0
2005/6	7	7	2	1
2006/7	24	7	4	1
2007/8	26	7	1	
2008/9	22	5	2	
Total	**103**	**43**	**14**	**5**
Overall total	**165**			

Findings:

- Women aged 16-25 (62 per cent) are most likely to contemplate and attempt suicide and self-harm, and those aged 26-36 (26 per cent) are the next likely group.
- Women who contemplate and attempt suicide and self-harm tend to be younger than those who commit suicide (see below for ages of suicide cases).

CAUSES OF CONTEMPLATED/ ATTEMPTED SUICIDE AND SELF HARM

The sample group showed a high correlation between domestic violence and suicide and self-harm (see chapter 1 for more details on the sample group).

Domestic violence

Box 1 illustrates the case of 'Balwant' who attempted suicide as a cry for help. SBS was able to assist this 23 year-old Asian woman to escape domestic violence and a forced marriage to a man, whom she met for the first time on her wedding day.

BOX 1

Balwant married in India, and joined her husband, a British national, in the UK. From the start she was physically and sexually abused by her husband and mentally harassed by her mother-in-law. Balwant was subject to degrading treatment, including being tied up and penetrated by objects. Forbidden access to a doctor or hospital, despite her injuries, she was imprisoned within the home: her insecure immigration status meant she was frightened to leave.

In March 2002, due to escalating violence, Balwant took an overdose; for the first time a family friend was allowed to visit her. The husband and in-laws warned the friend that she could not take the woman to the hospital and that her friend had to talk to her about 'behaving' herself if she wanted the marriage to work and not be deported or disowned. Eventually, the friend approached SBS. SBS assisted Balwant to leave home and obtain medical treatment for her physical injuries. SBS also helped Balwant to obtain settlement and provided her with essential counselling to overcome post traumatic stress disorder caused by previous abuse.

Other cases, like that of 'Gurpreet' in Box 2 (see chapter 1 for more details of the case), also highlight how women can become suicidal because of domestic violence and the fear of being disowned by their own families. Like that of Balwant above, the link with immigration status is also clear.

BOX 2

Gurpreet had married in India at the age of 22 and soon afterwards joined her husband in the UK. While here, she experienced domestic violence from her husband and in-laws, who accompanied her whenever she went out. Gurpreet grew depressed and attempted suicide by cutting her wrists with a knife. She had contemplated setting herself alight several times before.

Gurpreet felt she could not leave her husband because of her insecure immigration status; she did not know where to go for help, she had no income and nowhere to live.

At interview, Gurpreet said: 'My husband threatened to divorce me and to send me back to India. My parents would not accept me back and people in the community would not have let me live. My father said that I could only return when I was dead. In the end, I did not kill myself because I felt it would not benefit anyone'.

Forced marriage

Forced marriage is also a cause of attempted suicide and self-harm, especially amongst younger women, as shown by the case of 'Yasmin', see Box 3 below, who had already been forcibly married to an unsuitable overseas cousin by her family.

Restoring honour

Suicide and self-harm may be used to restore honour or, in some cases, to bring shame and dishonour. For instance, one woman asked SBS: *'If I wrote a suicide note naming my husband and family, would that dishonour them?'*

The need to preserve family honour (or *izzat*) is a common feature in many cases. In the case of 'Sukhwant', see Box 4 below, it arose in connection with the stigma of separation from her husband. Despite verbal and physical abuse from him and his family, she attempted a reconciliation to try to restore her family's honour.

Severe depression

Some cases of attempted suicide and self-harm are complicated by a pre-existing mental health condition. 'Rajinder', see Box 5 below, suffered chronic depressive disorder aggravated by an acute stress reaction to environmental factors such as abuse and sexual exploitation. (See chapters 1 & 2 for more cases studies and information on attempted suicide and self-harm and compounding factors such as immigration status.)

COMPLETED SUICIDE

Over the years, SBS has dealt with about 18 deaths of BME women resulting from suicide (although the cause of death in six of these cases was officially unknown, some family, friends or the authorities suspected they may have been suicides). During the period of the Project, from April 2001 to March 2009, SBS dealt with eight deaths. Prior to this, there were ten cases, some of which have been included in this analysis in order to show trends and patterns. Seventeen cases involved South Asian women from Hindu, Muslim and Sikh backgrounds.

All of these cases were brought to the attention of SBS after the women's deaths by a relative, friend or an agency wanting to know what happened, to obtain

BOX 3

Yasmin was heavily pressured to marry because her dying mother wanted to see her settled. Relatives threatened to ostracise her if she refused and her violent father threatened to kill her. Joining her husband in the UK, Yasmin felt that:

'This was the worst day of my life because I didn't want to see him and he physically repelled me. I couldn't bear to look at him, and they wanted me to spend the rest of my life with him. I didn't even see him as a human being. I hated him. We went to London and it was just me and him, sitting in the room silently. I tried to start conversations, but it didn't work. He was in his own little world. I got an Asian TV channel for him, and everyday he would wake up at 10am and watch TV and not make any effort to talk, or help himself in the kitchen, or do anything. I was out at work all day and when I got back I had to slave for him day in, day out. I told him the doctor said there was something wrong with me and I wasn't allowed to have sex for a couple of months. I lied to him, and I lied to the family so they wouldn't force me to sleep with him. But I became depressed, a nervous wreck. I cried my heart out, but the family said I had to go along with it. It was my fate. It was my destiny'.[13]

When Yasmin could no longer tolerate her situation she contemplated suicide by taking an overdose and using sharp knives on herself. The timely arrival of a friend persuaded her to leave her husband rather than commit suicide.

BOX 4

Sukhwant withstood verbal and physical attacks from her husband and in-laws when she joined her British husband from India. They demanded more dowry from her and controlled all her movements. As a result, Sukhwant developed severe depression and suicidal feelings. Four months into the marriage, Sukhwant was sent back to India, where she became a centre of local gossip and scrutiny. The community blamed her for the breakdown of the marriage.

Sukhwant hated herself for being a burden on the family and a source of shame. As a result of this pressure, Sukhwant decided to try to obtain a reconciliation and sold her jewellery to return to the UK. She found her husband had moved away, and through an acquaintance she found employment in a factory. Eventually her husband contacted her, and she returned hoping to restore her family's honour through a reconciliation. However, their relationship soon deteriorated: he had become an alcoholic and had accrued a number of debts. He took all her savings and salary, and treated her like a slave. Sukhwant worked days in the factory and cleaned and cooked all evening, and was isolated from her family. Within a few weeks, she was told to leave again.

Her employer helped her to find accommodation and referred her to SBS, who helped her to make a recovery through advocacy and counselling. She is now in a new relationship which is supportive and kind, and says she has found comfort, a new family and a sense of independence at SBS. In particular, she is overcoming a sense of shame and self-blame for the breakdown of her abusive marriage.

BOX 5

Rajinder is 31 year old Asian woman who had a history of deliberate self-harm, having attempted suicide nine times, including massive overdoses, stabbing herself and jumping into a well.

Her father was abusive to her and her mother. Her mother had committed suicide by setting herself alight. Rajinder had been trafficked into other countries by men in India and appeared to be in prostitution in the UK. She had been raped by her pimp in India who had also previously tried to kill her, and her violent alcoholic father had disowned her. She was facing deportation from the UK after her asylum claim was rejected.

She contacted SBS after taking an overdose. SBS ensured she obtained emergency medical help and access to psychiatric help for on-going work. Unfortunately, Rajinder did not remain in contact with SBS despite attempts to contact her.

expert evidence and/or to raise issues with the police and the coroners' courts. We often help bereaved relatives and friends of the woman to obtain legal advice, as well support them through the inquest process. Eleven of these cases were local to the Southall or surrounding area. Others were located in the Midlands, or other parts of London. Most women appear not have reported the abuse. From the information available on these cases, only one woman had returned home after entering a refuge, four had reported abuse to the police and three were known to the mental health services prior to their death. Family and friends stated this was often because of isolation, lack of awareness of services, considerable religious and cultural pressure within the family or community preventing them from seeking help, fear of reprisals or being deported, or the failure of agencies to believe them and offer assistance.

Methods

The following were the methods used in the suicide cases:

Hanging	Jumping	Burning[5]	Overdose	Unknown[6]
7	4	4	1	2

[5] One case of burning also involved stabbing.

[6] How these two women died was not established either because the body was too decomposed or because medical experts could not agree.

The most common method of suicide was hanging, while jumping from a height or in front of a fast moving vehicle, such as trains, and burning were the next two most common. Unlike many of the self-harm cases, these methods seem to indicate an intention to commit suicide, rather than a cry for help or a gesture, as there is little chance of survival and because three also included deliberate killing of their children.

Age

The following is the age of the suicide cases (where known):

Cases	16-25	26-36	37-47	48-67
16 cases	3	8	3	2

The SBS Project found that unlike the attempted suicide and self-harm cases which

affected mostly the younger age group, the majority of the suicide cases were slightly older at 26-36.

Causes of completed suicides

All cases involved domestic violence or other abusive or oppressive practices within the family, such as forced marriage. These experiences included:

- Physical and sexual assaults
- Forced marriage
- Threats, mental abuse and emotional blackmail.
- Isolation and imprisonment
- Deprivation of food, domestic servitude and restrictions on lifestyle
- Harassment for not bringing in enough dowry and confiscation of income
- Pressures to preserve the honour of the family and even that of the community
- Allegations of adultery or 'loose' moral behaviour
- Lack of family and community support and pressure from them to make marriage or family relationships work at all costs as well as subjecting women to ostracism and harassment if they do not
- Fear of inability to care for children or protect children's marriage prospects if they are divorced
- Shame of divorce and single parenthood, and for not having a son as the first born or having an illegitimate child
- Insecure immigration status and destitution
- Bereavement
- Stigma of depression and mental health problems

In 1995, 'Aisha', a 55-year-old Asian woman, was killed by a train when she walked on to a railway track in Northolt, West London. Just prior to her death she had fled to a refuge to escape domestic violence from her husband:

BOX 6

Aisha told the refuge that her husband had, on several occasions, punched, slapped and verbally abused her. She was not allowed to leave the home; much of the time her husband kept her locked in one room; and her money was restricted to £20 per month. She had also suffered verbal insults from her mother-in-law.

Aisha later reconciled and returned to her husband, but less than a month later, she was dead.

The case of 'Harjinder', a UK born Asian woman, who committed suicide in 2005 in Southall, was complicated by domestic violence and mental illness. Her marriage failed and, under pressure, an unsuccessful reconciliation was effected but, left to cope on her own, Harjinder took her own life. Shortly thereafter her mother also killed herself while bereaved by the loss of her daughter and grand children.

BOX 7

'Harjinder' was a 27 year old Asian woman born in the UK. Harjinder met her future husband in India and married in 1996. Harjinder's first child was a girl; because the family had expected a first-born son, she felt she had let them down. Her domineering mother-in-law criticised her cooking and housekeeping.

In 2004, having reported an assault to the police, her husband was issued with a formal caution. He left her and returned to India, threatening divorce. Her in-laws and relatives accused Harjinder of bringing shame and dishonour on the family as a result of the separation. A reconciliation was effected and the husband returned home on condition that he would not do any domestic chores and she would not call the police again. Her husband neglected his responsibilities, and Harjinder struggled to cope on her own.

Harjinder became overly anxious that she was not caring for the children properly, although there was no evidence to suggest that this was the case. Her GP diagnosed depressive illness of moderate severity, which became more acute in a crisis. She admitted feelings of suicide and self-harm to the doctor during 2004, particularly when her husband left, even though she said she had no intention of killing herself because of the children. After their reconciliation, she told medical staff that the situation at home was worse than ever and regretted going to India to reunite with her husband. At various times, she told staff that she did not want to bring up the children on her own as her mother had done.

In August 2005, Harjinder jumped in front of a train with her two children. Six months later, Harjinder's mother also jumped under a train on the same spot as her daughter. Her suicide note said that she could bear to be without her children and had been in receipt of bereavement counselling and anti-depressant medication.

Other causes of suicide are linked to forced marriage or women being found to have formed relationships outside marriage, as illustrated by the case of Gurdev:

BOX 8

In 1996, a 17-year-old Asian woman, Gurdev Sohal, was found hanged after she had confessed to a relationship with a Caribbean man. Her father had even offered his unwound turban as a noose.

SUICIDE PREVENTION

SBS involvement with suicide cases is aimed at raising issues of public concern and preventing future fatalities through more effective early intervention by agencies. The use of homicide legislation and criminal courts to tackle cases of women driven to suicide in the context of domestic violence is discussed in chapter 4. This chapter explores SBS's use of the coroners' courts to investigate cases of suicide. Although coroners courts have been reluctant to investigate the history of violence a woman may have suffered prior to her suicide, any reference to such a history in the coroners' summing up can have a powerful impact on family and community

and provides affirmation of what family and friends may have been alleging in the case of abused women.

Coroners' courts

SBS is unique amongst domestic violence organisations in using the coroners' courts following a suicide or a suspicious death to raise issues of public interest and thus to prevent future fatalities. When Krishna Sharma hung herself after years of domestic violence in 1984, the coroner pronounced a verdict of suicide but SBS argued that Krishna had been to driven to kill herself as a result of her husband's abuse.

In 1996, one coroner, James Turnbull, seemed to agree with this when he commented on BBC Television[14]:

'It might be unfair to suggest that there have been cases of unprovable murder, but I strongly suspect that there have been cases of provable encouragement to suicide, which is nearly the same thing.'

However, most coroners refuse to allow evidence of domestic violence to be introduced or reports by expert witnesses on issues affecting black and minority women. Coroners often argue that the coroners' courts' rules limit their remit to examining the 'how' rather than the 'why' – the facts of who, what, where and method by which the person died rather than the reason for their death. Although the state of mind of the deceased and circumstances in which the death occurred is relevant in cases of suicide in order to show intent and that it was a deliberate act, beyond all reasonable doubt, coroners usually confine their investigation to the immediate circumstances leading to their death, ignoring the history of domestic violence and its cumulative effects. As a coroner said in one case: *'I do not intend to have an in-depth investigation of the marriage, but only what happened on the night of the death'.*

State of mind and intent are often established through suicide notes and witness, pathologist and medical evidence. However, this is often about establishing 'whether' rather than 'why' they were depressed or mentally ill. For example, in one case of suicide in 1993, 'Sonia', a 26 year old Asian woman who set herself alight was simply labelled as 'confused' by the police and the coroner after reading the contents of her suicide note, killing herself for no apparent reason according to them despite the fact that the note and her brother had raised concerns that she had been depressed about her husband's infidelity and mistreatment. Like many other agencies, coroners prefer medical explanations, such as psychiatric disorders, rather than social causes of suicide.

Coroners have generally been very resistant to acknowledging the causal or contributory link between domestic violence and suicide, even in cases where there is strong evidence. The case of 'Aisha' (see Boxes 6 & 9) highlights this point. After her death, her family in India and her friends were too nervous to be witnesses and she had no one to speak for her at the coroners' court.

Another missed opportunity was that of the case of 'Harjinder'(see Box 7

BOX 9

SBS decided to speak for 'Aisha' after her death, in the absence of other witnesses. We made third party representations to the coroner, who was willing to accept expert and factual evidence from SBS but refused to recognise us as an 'interested person' or party in the proceedings.

Aisha's husband claimed she suffered from 'mood swings' and her doctor wanted to refer her to a psychiatrist after she went missing for a period and when they found two suicide notes.

Although expert and domestic violence evidence from SBS was accepted as providing background information, the coroner failed to acknowledge the recent history of abuse which contributed to Aisha's death. Given that her suicide took place on the railways, the inquest was held with a jury which is required for inquests involving public authorities and they returned a verdict of suicide.

above). The coroner returned a verdict of suicide for Harjinder (and her mother) and unlawful killing of her children as a result of a mental illness. The coroner ignored the impact of aggravating factors of abuse and neglect on her illness which was said to be more acute during a crisis.

It appears that the response of coroners is not unique to the SBS experience. For example, in one reported case, that of Noreen Akthar, (see Box 10 below) the coroner failed to establish a link between forced marriage and suicide in an attempt to be culturally sensitive. The coroner decided to leave it to the community to resolve the problem caused by a 'culture clash' produced by an 'arranged marriage', rather than publicly criticising the inhuman act of forcing women into marriage and calling on the government to challenge it.

However, in one case, that of 'Rani' (Box 11 below), although the role of abuse was not accepted, the impact of an insecure immigration and 'marriage difficulties' was recognised.

In another case, in May 2007, the coroner, at an inquest into the death of 'Rajdeep' in what appears to be a breakthrough preamble to the verdict[15], accepted that she had committed suicide by hanging as a result of the pressures of living with her parents-in-law, who subjected her to incessant criticism, long hours of work at home and their family business and false allegations of 'immoral' behaviour such as adultery. The coroner stated[16]:

'Since [being] married in or about the mid-1990s, [Rajdeep] lived together with her husband and their two children and his parents. [Rajdeep] worked in her husband's family business as well as caring for her children and taking a substantial role in the running of the family home. In 2001, [Rajdeep] and her husband bought a house with the intention of moving in, but this arrangement fell through and the property was sold and the proceeds re-invested… it was not until around mid-2006 that [Rajdeep], previously a non-smoker, started smoking; a practice frowned upon by her own

BOX 10

In 2002, an inquest into the case of Noreen Akthar found that she had hung herself after going ahead with a marriage arranged by her family. In her suicide note she said 'I wanted to keep you all happy. I also wanted my own happiness – I couldn't have both'.

A consultant psychiatrist who had been treating Noreen told the inquest that she was depressed because she did not identify with traditional Islamic values regarding women and came under pressure from the family to accept an arranged marriage.

The coroner said the tradition of arranged marriage sometimes meant women were caught between two worlds. He said 'I don't seek to minimise it. I hope that members of the Asian community will recognise this as a real problem. It needs addressing, and if there is any integration and marrying of the cultures, a way forward ought to be looked for with great seriousness'[17]

family members and her in-laws… a family conference was held between [Rajdeep], her husband and her in-laws in which the matter of her smoking was discussed. Mention was also made of [Rajdeep] having been seen changing her clothes in a car. During this meeting [Rajdeep] became upset. [Rajdeep's] father-in-law stated that he would inform [Rajdeep's] father about her smoking and purported to meet with him that weekend. That meeting did not take place… on (…) October 2006, [Rajdeep] carried out her usual work routine, she gave no indication to her husband that she remained upset after the family conference… and the day progressed as normal until [Rajdeep] was found by her husband hanging from the stairs in the flat above the shop.'

After the verdict, members of Rajdeep's own family felt that reasons for

BOX 11

Rani at 41 underwent a religious Hindu marriage ceremony with a UK national in India. She was sponsored as a visitor into the UK in December 2002 and then married her husband at a civil ceremony. Her husband said that he would regularise Rani's status but did not appear to have taken any steps to do this.

In October 2003, Rani died after ingesting poison – pesticide she had brought from India. Her husband had bought her a one-way ticket to India. Through her friends, SBS became aware that the husband was subjecting Rani to emotional and verbal abuse; and that she had been married once before and had told them that she could not bear the shame of returning to India again and dishonour her family as a second time divorcee. After her previous divorce, she had been ostracised by her family and community in India.

At the inquest in May 2004, the coroners' courts' suicide verdict stated that 'Rani' '... was having difficulties with her marriage and was concerned about her immigration status.'

her death were clear and said:

'It took 10 years of waiting and suffering before [Rajdeep] gave up and killed herself. Her husband started to house hunt on the day before her death after the family conference where there was an argument – this was a case of 'too little, too late', [Rajdeep] had given up all hope and could not be placated'.

Ultimately, many families want to know the reasons for the death. As Rajdeep's brother said:

'Nothing is going to bring my sister back. However, the questions must be asked and answers found. For the sake of her two children the reasons why she was so unhappy must be made public so that they do not grow up and live the rest of their lives wondering what caused their mother to take her own life.'

Over the years, SBS has addressed a number of specific issues which arise in the coroners' courts when attempting to determine cause of death and prevent future fatalities. These are outlined below.

Suicide or homicide?

Unless there was overwhelming evidence to the contrary, SBS does not, in the first instance, assume that the death was caused by suicide. There are concerns that some deaths are suspicious and could be murders disguised as suicides or accidents. This is particularly relevant in communities where domestic homicide – and so-called 'honour killings' – are often either covered up by the extended family and community, or are not properly investigated by the police for fear of interfering in minority cultures.

SBS has raised these concerns with the police and the coroners' courts. However, the police often do not treat the initial report of a death which appears, on the face of it, to be a suicide or accidental as suspicious. By conducting a cursory investigation, they often fail to secure forensic or witness evidence. Moreover, the coroner at the inquest may refuse to pursue this line of inquiry, particularly when the family and community close ranks and refuse to co-operate with any investigation or inquest.

This is illustrated in the case of Nazia Bi and her daughter Sana. (see Box 12 below), who both died in a house fire in 1999.

In another case, that of 'Baljit', her children suspected that their father had murdered their mother, but this was impossible to verify due to insufficient evidence. The police had not collected any forensic evidence at the scene where Baljit's body was found, nor (until the daughters made a complaint) had they collected witness statements. See Box 13.

Third party intervention

The Nazia Bi case (see Box 12) highlights the need for more third party interventions in coroners' courts. In some cases, family and friends of the deceased are unable or unwilling to act as an 'interested person'. This is where family and/or community close ranks and do not want the death of a woman in a context of domestic violence to be investigated and/or there is a fear of reprisals against anyone who does. This also occurs where perpetrators want to avoid culpability leading to civil or criminal action against them or where there is little desire to uncover and challenge abusive behaviour. Rather, there is an acceptance that a suicide may help the woman to 'admit'

BOX 12

Moments before Nazia and her daughter died in a house fire, she had called the emergency services saying 'my husband burned me, please help me'. Previously, Nazia had informed the police that due to domestic violence she was about to leave her husband.

Nazia's husband was charged with murder. Although the case was initially dismissed by the Magistrates' court due to insufficient evidence, the Crown Prosecution Service applied to reopen the case. But in Sheffield Crown Court, the case was dismissed again on the grounds of insufficient evidence and a verdict of 'not guilty' entered. The judge ruled that the crucial tape-recorded message where Nazia accused her husband was inadmissible. The judge looked at the possibility of 'concoction' of this statement by the deceased and excluded the tape on the basis of witness statements alleging Nazia had threatened to burn down the house and destroy her husband's furniture. They argued that she accidentally killed herself and her daughter when she had lit the fire. Other witnesses argued she had committed suicide, faked the telephone call to the police as revenge against her husband. One of these witnesses subsequently married Nazia's husband. The witnesses' evidence was never tested in court.

Until SBS became involved in 2001, the history of domestic abuse in the case and the circumstances around the deaths remained unexamined. SBS wrote to the coroner, requesting that the inquest – which had opened prior to the criminal case – be resumed. (Nazia's family were related to the husband and had declined to reopen the inquest. Nazia's friends were too frightened to come forward.) SBS argued that evidence ruled inadmissible in the criminal case could be considered in the inquest to establish the cause of death. SBS requested that it be recognised as an 'interested person' in the proceedings.

Although he accepted SBS could give expert evidence in the case, the coroner refused to resume the inquest, and would not recognise SBS as an interested party with a right to request or intervene in proceedings. SBS judicially reviewed the coroner's decision, quoting, amongst other human rights laws, the United Nations Convention for the Elimination of All Forms of Discrimination against Women 1979 (CEDAW) as an innovative legal argument for permitting such interventions.

This was the first time a voluntary group had challenged a coroner's decision not to recognise them as an interested party in a domestic violence case. Whilst permission for a judicial review was not granted, the judge accepted that:

SBS was acting in the public interest by making the application for a judicial review
The coroner did not award any legal costs against SBS
The coroner agreed that SBS had standing in judicial review proceedings if they were to go ahead
As SBS had not known the victim before her death, it could not act as an interested party.
The coroner had the discretion to refuse to hold an inquest in this case as the case had been handled by criminal proceedings (albeit without trial).

However, SBS felt that there had been insufficient public scrutiny of the case, and that the coroner refused to hold the inquest in order to be 'culturally sensitive'. To date, the cause of Nazia and her daughter's death is unknown: suicide, accident or murder.

BOX 13

Baljit, a 45-year old Asian woman, hanged herself in June 2000. Baljit had been subjected to repeated abuse by her husband in a 23-year marriage, especially when he had been drinking. She told her daughters she had been raped, endured his affairs and visits to prostitutes. He had also been violent to the children. Baljit had exchanged solicitors' letters about divorce, none of which had been followed through.

In 2000, Baljit's husband went to India, again threatening divorce. This time he was due to remarry a younger woman. He accused Baljit of infidelity and denied paternity of their young son. Baljit's own family pressured her to save her marriage: allegations of adultery would dishonour her family and ruin her daughters' marriage prospects. She travelled to India, where her son alleged that his father attempted to throw Baljit in front of a train. The husband escorted Baljit back to the UK, where her children took photographs of her bruises following a severe beating. On the day of her death, he had left her once more to return to India.

Upon the discovery of her body, the daughters reported to the police that they suspected either that having killed Baljit, their father had fled or had only accompanied her to the UK as part of a plot to dispose of her. The police investigation concluded that they were 'satisfied' that her husband had checked in at the airport at the time Baljit was likely to have killed herself. But the time of her death was estimated and imprecise. Other forensic evidence had not been collected at the place of Baljit's death, and it had not been treated as a 'crime scene'. Due to lack of evidence, Baljit's children eventually argued that their father actively assisted or had driven her to the desperate act of suicide. A verdict of suicide was returned by the coroner.

her guilt and remove the stain of dishonour. For example, in the case of 'Baljit' (see Box 14) her suicide helped to prevent the dishonour of divorce, which protected her daughters' marriage prospects and her son's legitimacy in the eyes of the community. In the light of this, relevant organisations such as BME women's groups with a track record of working on issues of domestic violence should be able to make interventions in order to raise issues of public interest.

Expert evidence

Although several coroners have allowed expert testimony in order to explain cultural and religious pressures on Asian and other minority women, the impact of such pressures in an abusive situation is often ignored. For example, in the case of Baljit (see Boxes 13 & 14), the coroner revealed ignorance of the dynamics of domestic violence, and how religious and cultural pressures make women stay within an abusive marriage.

In another case involving a 34 year old woman, 'Sonia' the coroner heard expert evidence on Asian women and domestic violence from the police, but then refused to allow Sonia's parents and brothers to discuss the abuse she had faced. The coroner also did not consider how cultural pressures may have aggravated her mental illness.

In an expert report to the coroner in the case of 'Harjinder', (see Box 7) SBS highlighted the relationship between

BOX 14

At the inquest in September 2001, the coroner accepted that Baljit had been subjected to domestic violence in the past. Despite photographs of injuries, and admission by the husband via his counsel that these injuries were recent, the coroner ignored the evidence of current domestic violence, stating women may nag or provoke men into violence.

In addition, he argued that the impact of shame and dishonour was not specific to Asian women, but something prevalent in the British aristocracy and compared Baljit's case to that of Prince Edward VIII, who had to abdicate from the throne because he brought dishonour to the monarchy and the country by marrying a divorcee. The coroner failed to appreciate that the concept of honour, which has somewhat diminished amongst the British but still very powerful within minority communities, has particularly severe consequences for women who refuse to conform to traditional expectations within the family.

The coroner displayed little or no understanding of modern realities. He concluded that Baljit was suffering from depression brought on by the prospect of divorce. He failed to understand the cultural context in which Baljit found herself: the threat of divorce is part of a pattern of abusive behaviour intended to intimidate women into silence and stigmatise them if they do not.

depressive illness, domestic abuse and cultural pressures. The coroner considered the evidence, but then failed to take it into account in the verdict.

In the case of 'Rajdeep', the coroner refused to accept expert evidence from SBS, although it had prepared and submitted a report to the inquest. The SBS report pointed out that Rajdeep would have been particularly concerned about her father knowing about her smoking which is an indicator of worse 'morally loose' behaviour, such as adultery, and which was another allegation made against her by her in-laws. This would have been extremely shameful. The report also addressed a number of other issues, mainly the fact that Rajdeep wanted to move out of her in-laws' house so that she could escape their controlling and oppressive behaviour. Although displaying ignorance on some aspects of culture (for example, the coroner assumed that Rajdeep was the 'matriarch' when she was seen doing all the housework, rather than appreciate that this indicated she was at the bottom of the family hierarchy), the coroner, however, informally accepted parts of the expert report as her preamble to the verdict which indicated some understanding of cultural pressures.

However, there is some way to go in ensuring that evidence of domestic violence and its impact on BME women is acknowledged as illustrated in the case of an Asian woman, 'Jasvinder', who died in 2005 of unknown causes after experiencing domestic violence. At her inquest in 2008, the attitude of the coroner, and the police officer who had been asked to investigate the case, was that of disbelief. The police officers stated that 'Asian women were less likely to regard forced sex in marriage as rape' and the coroner concluded there was

no evidence of domestic violence despite previous reports made to the police by the deceased herself.

Preventing future fatalities

The role of an inquest is not to apportion blame or to hold a 'trial', but it does have an inquisitorial (rather than adversarial) function and to that extent has a duty to have regard to Article 2 (right to life), Article 3 (the right not to be subjected to torture or to inhuman and degrading treatment or punishment) and Article 14 (the right to non-discrimination on grounds such as sex, race etc) of the 1950 European Convention of Human Rights (ECHR). Recognising domestic violence as a causal or contributory factor is extremely relevant as it recognises the state's responsibility in protecting women's human rights under Articles 2, 3 and 14 and the role of public bodies in exercising due diligence, [18] and thus preventing suicide.

With reference to failure of the state to protect its citizens, rule 43 of the Coroners Rules 1984 allows the coroner to raise issues of public policy and make recommendations to agencies to improve practice in order to prevent future fatalities. But this is rarely used in domestic violence cases. For example, it was not done in the case of 'Baljit' (see box 13) where there was evidence that some agencies failed to prevent further abuse. The police had failed to follow up the case after attending an incident of domestic violence. Although the GP had referred Baljit to a counsellor, to whom she had reported domestic violence, the GP had not obtained any feedback from the counsellor, which would have enabled the doctor to talk to Baljit about obtaining help. Nor had the counsellor made a referral to agencies for assistance.

In Rajdeep's case the coroner was reluctant to widen the ambit of the inquest by appointing a jury and addressing health and safety issues raised by the case. The coroner said that she was 'horrified that families were suddenly open to scrutiny', but failed to recognised that abuse within the family was an issue of public and not private concern and needed to be addressed through a recommendation to public bodies. The coroner also rejected submissions to undertake an Article 2 inquiry and to make a recommendation, at the very least, to the Secretary of State to improve collation of statistical data on ethnic minority suicide rates. (SBS also raised these issues in the Home Office Coroners Review consultation. See chapter 4.)

STRATEGIC HEALTH AUTHORITIES

SBS has attempted to raise issues concerning BME women and domestic violence with some health authorities in order to prevent suicide. For example, in the case of 'Sonia', in 2003 the Strategic Health Authority conducted an independent enquiry into her death and that of her three-month-old daughter after the coroner returned a verdict of suicide for Sonia and unlawful killing by Sonia of her daughter whilst the balance of her mind was disturbed. SBS gave evidence at the enquiry. The report did not explore Sonia's history of emotional abuse within her marriage, such as jealous and controlling behaviour by her husband, but focused more on the failures of the health

service in providing adequate healthcare as Sonia was already known to the authority as suffering from a bipolar affective disorder. It suggested that the stigma of mental illness within the medical profession had an impact on her as she was also a psychiatrist working for the health authority. The report recognised that childhood sexual abuse would have added to Sonia's psychosocial stress, that her cultural background would have had an impact on her ability to disclose such abuse or to handle its effects and the stigma of mental illness, and that she would have been disadvantaged by general experiences of racial discrimination. It acknowledged the need to address these issues in mental health services. However, the report also placed Sonia's problems within the family as a 'cultural conflict' produced between her traditional parents and her white husband rather than recognise the effect of emotional abuse from her husband as alleged by her family.

In the case of 'Harjinder' (see Box 7), the health authority noted in its Serious Untoward Incident Report that Harjinder was referred to Relate by medical staff in charge of her care and treatment for depression. Although the report suggested that an organisation in the community would have been more appropriate for cultural reasons, it failed to note that Harjinder was also a victim of domestic violence who would have needed help on this issue if she was to overcome her depression. The report did not address the need for the health service agencies to be more aware and responsive to the problems of domestic violence which contributed to Harjinder's depression.

CONCLUSION

As SBS's work shows, suicide and self-harm are significant issues facing BME women experiencing domestic violence – indeed wider research supports our view that for Asian women at least, the rate of suicide and self-harm is disproportionate when compared to women in the general population. The government and the courts, particularly the coroners' courts, have a key role in preventing future fatalities, but current initiatives and responses are inadequate (see chapter 4 for further analysis of current initiatives). This area of work therefore requires urgent action (see Recommendations).

CHAPTER FOUR

Improving Policy and Practice – The Way Forward

Professional agencies

Response of health services

BME women facing abuse share similar experiences when seeking medical assistance from their GPs and other health professionals, such as hospital consultants, nurses, midwives, health visitors and supporting administration and reception staff across all health services including accident and emergency wards, maternity, family planning and other clinics. Many BME women who come to SBS have visited the GP with symptoms of stress, depression or mental illness. Others, however, are unable to obtain treatment because they have been prevented from doing so by their families, or because they are unable to register with a GP due to their insecure immigration status. Some women do not go to their family GP because they fear breach of confidentiality. The GP may be in close contact with other family members, who may be perpetrators of the abuse. There are also concerns that some GPs, particularly those from within the community who have conservative cultural and religious views, are more likely to share information, and be unsympathetic and even hostile towards women who complain about domestic violence. These problems are highlighted by women at SBS. In an SBS focus group, one woman said [1] :

'I think when people register at a GP, it needs to be explained to them that the information they give there won't be passed on to anyone else and that they can talk about any problems they have there, especially girls from foreign countries. It should be made clear that the GP surgery is a confidential service. One of my friends can't talk to her GP because she is worried that because he is a very good friend of her husband, he will talk to her husband... because she told her GP something and he immediately told her husband, her husband raised his hand to her again and now she can't go to the GP. She is not allowed to go anywhere anymore.'

Many women also find that they are unable to discuss problems of abuse and violence with GPs and other health professionals as they are always accompanied by their husband or family members, who give their own 'explanations ' for any physical injuries or emotional distress, particularly if the woman is unable to communicate in English. Health professionals also rely on family members, including children, to help with interpretation, and even professional interpreters may breach confidentiality by talking about the case in the local community or being judgemental about the woman's decision to report abuse. Some women also find it difficult to express their anxieties or lie about the reasons for stress for fear of reprisals, being disloyal to their husbands and family, bringing shame and dishonour, and/or being labelled as being 'mad'. Some present with psychosomatic problems where the psychological causes, based on the experience of abuse, of 'aches and pains' and other ailments remain unacknowledged.

Some BME women complain of racism and discrimination by professionals who may stereotype their behaviour. Some GPs and health professionals make the assumption that Asian women in particular are submissive, and do not recognise the symptoms of depression or the abuse which caused the depression. Others assume Asian

women were unwilling to act against abuse for cultural and religious reasons, or accept the family's interpretation that women are 'mad', even where they are simply 'rebellious' and challenge practices such as domestic violence and restrictions on their lifestyles. Some GPs or health professionals who know that the women are not mentally ill, may, nevertheless, be unwilling to be seen to be interfering in a minority culture or religion, as required by multicultural or multi-faith policies (see Introduction for more information), and therefore fail to encourage to take action against abuse.

On the other hand, African and Caribbean women challenging domestic violence may be seen as being 'aggressive', which is often assumed either to be the 'norm' for women from such communities or a symptom of mental illness. African Caribbean women, in particular, experience blatant forms of racism and stereotyping and they are over-represented in mental hospitals and medium secure units.[2] In an SBS survey[3] which asked agencies about the experiences of women from different ethnic groups, many reported such problems for African Caribbean women. One respondent said,

'My experience is that Black, African and African-Caribbean women particularly have to deal with very rigid stereotypes: patois, yardies, lots of children, druggies. Often clients feel they have to live up to that self-fulfilling prophecy. ' Another said, 'There are discrimination issues in the way that they are treated when they are using psychiatric services. Often when using services they are made to feel problematised, [given] inappropriate diagnosis. There are high doses of anti-psychotic medication, poor care planning, lack of referrals to alternative treatments and lack of referrals to services in general.'

(See Appendix 1 and 2 for more information on this and the experiences of other minority women.)

Some women experience problems with safety within health settings where there may be inadequate security measures. For example, in the case of 'Kuldeep' (see Box 1) who eventually died in a context of domestic violence, there was a concern that her husband and family members would harm her when was taken to the hospital with severe burn injuries.

In another case, an Asian woman, who also entered hospital with severe burn injuries, suffered brain damage and went into a coma after her husband and his family visited her. She had told the hospital staff that she did not want to see her husband and in-laws as there was a history of abuse. Her family were suspicious that her husband and in-laws caused the severe burns when she was at home, and further injury when they visited the hospital. These cases highlight the need to improve security in health settings where a patient so wishes or there is strong suspicion of abuse, and to limit access to health records and visiting rights by abusive family members.

Many GPs who diagnose a mental health problem often prescribe anti-depressants or sleeping tablets. Forty five per cent of women from the sample group of cases and enquiries at SBS (see chapter 1) were known to be prescribed medication. Women with more severe symptoms of mental illness are usually referred to psychiatric and hospital services, with a few being sectioned. Only a minority are referred to counselling, psychotherapy and/

BOX 1

Kuldeep was a 24-year-old woman who had come from India to join her British husband in 2007. She lived with her husband and his family in Leicester, where they owned several properties. Kuldeep and her husband would have their meals in one home and sleep in another. Three weeks after arriving in the UK, Kuldeep started working in a factory from where she would contact her sister who lived in Birmingham. In January 2008, Kuldeep contacted her sister, telling her that her husband had beaten her early that morning, and although she had called the police, they failed to turn up as she had accidentally given them the wrong house number. She had also been subjected to verbal abuse by her in-laws, and an uncle had shown her a newspaper article of a woman who had been burnt to death.

Kuldeep had reported the violence to her GP, but on one occasion when her husband had insisted on going with her to the doctor, he managed to read the medical notes where these reports had been recorded. Eventually, Kuldeep left her husband and went to live with her sister. She told her sister that she had been starved at home and her diet was limited to rotten fruit and Indian bread. She was only allowed three sets of clothing, and she had to give all her wages to her husband. She was also not allowed to watch TV and was subjected to a range of other abuses.

While with her sister, Kuldeep had seen a solicitor and attended a woman's centre, but was advised that they could not assist as she was subject to the 'no recourse to public funds' requirement. Kuldeep then decided to return to the matrimonial home in Leicester as she wanted her marriage to work and because she did not want to dishonour her family. Her family had also pressurised her to reconcile with her husband.

Soon after returning to her husband, Kuldeep was hospitalised due to severe burns to her body. Her husband and his family had stated that she had tried to commit suicide by setting herself alight. They claimed that she had also left a suicide note stating that she felt suicidal after her husband had seen her medical notes. However, her own family suspected she had been set alight by her husband and his family.

Kuldeep sustained major burns to her body and was unconscious in hospital until her death in May 2008. Her husband and his family were allowed to visit Kuldeep in hospital prior to her death, despite concerns expressed by her family about the history of abuse and fears about further harm that they may inflict upon her while she remained unconscious. The police stated that they had insufficient evidence to charge the husband and his family, and the hospital stated that there was nothing they could do to prevent visits by the husband and his family.

or specialist domestic violence services for further help. For example, 'Aisha' (see Boxes 6 and 9 in chapter 3), who had been receiving medical help before she committed suicide, was not referred to a specialist BME women's domestic violence organisation. Although routine enquiry or screening for domestic violence exists in some health departments, such as maternity wards, many health professionals do not ask probing questions, fail to believe or are indifferent to reports of abuse. Even where routine screening does exist, some health workers do not know where to make referrals or ask appropriate

questions such as on harmful traditional practices. As one woman said in an SBS focus group, [4]

'I had a Bengali doctor and all my mum said to her was that I was married young. She asked my mum to leave the room so she could ask some questions, and then I told her I'd been forced into a marriage. The upsetting thing was that she knew about it but didn't do anything about it.'

One example, however, of best practice involved that of 'Rashpal', in Box 2, whose GP recognised that anti-depressant medication would only manage the symptoms not the cause of her depression. The GP referred her to counselling services and a women's centre.

BOX 2

Rashpal approached her GP for depression, but she was self-harming by cutting her wrists as a result of domestic violence and dowry related abuse. Rashpal was afraid she would be labelled as being 'mad' but the GP prescribed her anti-depressants to deal with her acute depression. The GP persuaded her that medication was only an interim measure while she obtained further assistance to resolve her underlying problems.

In another case, the woman said, [5]

'SBS recommended that I go to my GP... I hadn't gone before as it was support from this group that got me to go. When I went to the GP she was very helpful and instead of just prescribing medicine, she raised my confidence and gave me encouragement and support. She said well done for fleeing domestic violence and told me I was doing the right thing and getting the right support. She really assisted my self-esteem and didn't let me feel like I was going it alone. She really didn't want me to take medication; she wanted me to come through it in a different way. I had to move from my situation very quickly and I had to change my GP. SBS put me in contact with one and they put me on to counselling which has been really helpful in dealing with the violence I've been escaping from. '

Response of other agencies

The police and other criminal justice agencies, including the courts, probation and prison services, family and civil justice agencies, immigration services and detention centres, social services, education, housing, and other advice and welfare agencies also have contact with BME women. They can help to protect BME women from abuse by enabling them to access appropriate health and domestic violence services. However, many of these agencies either do not recognise the need for medical or counselling assistance, or ignore women's rights to welfare and social care services or justice, as highlighted in the case of 'Nina', whose mother-in-law attempted to use Nina's depression to discredit her in court so that Nina's husband could obtain a residence order for their child. The courts took her statement seriously. The mother-in-law said:

'I fully support my son's application for residence and believe it would be the [child's] best interest to reside with the applicant as opposed to the respondent [Nina]. I am concerned [about]...the respondent's history of self-harm and believe that it is likely to happen again given the present circumstances. The respondent has been ringing us regularly since the court proceedings started. I do not think she is sure about what she is doing and I fear that she may become mentally unstable again. In the past she has tried to commit suicide and as a result was admitted to hospital. There is(sic) another occasion when she cut her finger and again was rushed to hospital. The respondent does this to get attention and to emotionally blackmail the applicant into doing what she wants.'

Rarely are both mental health and domestic violence issues dealt with effectively. Consequently, many women are reluctant to talk about depression or self-

harming behaviour in case it undermines their rights or general credibility.

Specialist provision

There are few specialist services to meet the needs of BME women due to lack of resources or awareness of their needs, or because of institutionalised racial and sexual discrimination. The services that do exist are fast diminishing. Many agencies do not have specialist workers or counsellors, and specialist organisations receive inadequate funding. Recently, this approach has been justified in the name of building social cohesion or integration between communities, which has led to the commissioning of generic rather than specialist provision (see Introduction for more information). In addition, the multi-faith approach has increased resources for faith based groups, rather than for secular BME women's services, thus undermining gender equality within the community.

In relation to mental health services, counselling or 'talking therapies' receive less resources or priority than psychiatric services, and where they do exist, there are often long waiting lists, time-limited counselling (often limited to 6-12 weeks) and a dearth of black female counsellors and psychologists; those who do exist may not offer free services under the NHS or may lack an understanding of how race and gender intersect and impact on the mental health of BME women facing violence. Where these issues are examined, using transcultural and cross cultural therapies, the emphasis is, more often than not, still on race. Indeed, some counselling services undermine best practice by using religious leaders or clerics to 'advise' and often provide 'alternative' forms of counselling within BME communities. This practice can serve to reinforce conservative values which prevent many women within these communities to escape or challenge domestic violence or other oppressive practices which are justified in the name of culture and religion. Other services use family or 'couple' counselling models in inappropriate cases where the victim receives therapy with the perpetrators of abuse, or with family members who are uncritical of the abuse and unsupportive of the victim.

However, there are pockets of good practice which provide specific counselling for BME women with mental health and domestic violence problems. These exist in both the mainstream and voluntary sectors, including mental health and social care services, although much of it depends on individuals rather than institutional response *per se*. Some of the best practice exists in women's organisations, particularly BME women's groups, who support victims of domestic violence, and provide or refer women to counselling and other mental health services, or within some mental health agencies, which provide appropriate treatment and referrals for victims of abuse (see section on the voluntary and community sector below).

Many professionals, particularly those in the voluntary sector, share our concerns about the response of the health services to the needs of BME women. In our survey of 36 organisations and those involved in our consultation exercises (see appendices

1 and 2), the majority of these found that gender based or domestic violence was the underlying cause of mental illness, and that health services, especially GPs, provided medication rather than counselling and social intervention to address the problem. They also argued for specialist provision which needs greater recognition by mainstream services. One agency said,

'agencies did not make appropriate referrals as they were unaware of specialist services, such as Chinese organisations. Mainstream agencies only contact them for interpretation services. Our services are not recognised by health professionals – we need recognition and respect, not dumping. '

GOVERNMENT AND MAINSTREAM INITIATIVES

Government and other mainstream initiatives on mental health have not, broadly speaking, targeted the needs of BME women, particularly those subjected to domestic violence. The NHS often provides generic services without being sensitive to gender or race issues, and where targeted work does exist, it is aimed at meeting the needs of other specific groups such as men who commit suicide or black people, particularly men, in the mental health system. The DH women's mental health strategy, while very progressive in its recommendations, has not been fully implemented or sufficiently targeted and resourced to meet the needs of BME women subjected to domestic violence. The DH's Victims of Violence and Abuse Prevention Programme (VVAPP) which has also not been implemented is the only DH programme which specifically targets mental health issues affecting BME women (and that of other groups) within the context of domestic and sexual violence. In order to develop an integrated approach, these strategies need to be included in policies on violence against women[6] and child protection. Legal and human rights obligations such as those outlined in the 1979 Convention for the Elimination of all forms of Discrimination against Women (see Introduction for CEDAW committee conclusions in UK 2008 as a result of mental health issues raised by SBS), the Beijing Platform for Action 1995 and Convention on the Rights of the Child 1989 also require an improved response from health services in tackling abuse.

Delivering race equality

The Department of Health's Delivering Race Equality (DRE)[7] five year action plan aims to tackle race discrimination in the NHS and local authority mental health services as a result of its obligations under the Race Relations (Amendment) Act 2000. The action plan was established following the publication of *Inside Outside*[8], which highlighted racial discrimination in mental health services for BME communities. Its recommendations were later embedded in the DRE framework for action[9].

Although the aim of the DRE is to have a 'whole systems' approach to mental health, and the development of 'appropriate, sensitive and responsive services', the needs of BME women are not mentioned under its action plan for specific populations. *Inside Outside* calls for 'culturally capable' services, but the standards by which these operate in relation to BME women, gender equality and domestic violence are not clear. Indeed,

there is a tendency to ignore domestic violence as an underlying cause of suicide and self-harm amongst BME women, where their experiences are reduced to a 'cultural conflict' and racial inequality. Moreover, it has encouraged or allowed the use of faith-based therapies, which undermine gender equality.[10] 'Culturally capable' services therefore need to be questioned for their implications for women's rights and reform is needed to avoid the use of faith-based groups, religious leaders and other conservative organisations in addressing mental health problems and domestic violence within minority communities.

Women's mental health strategy

In 2002, DH published its consultation, *Women's Mental Health: Into the Mainstream,* on their women's mental health strategy[11] which recognised the impact of violence and abuse on women's mental health and that BME women are amongst the vulnerable groups. The strategy acknowledged the need for gender sensitive services incorporating safe women-only services which also meet women's cultural and religious needs. It argued for a holistic approach to service delivery adopted in partnership with service users, including the need to tackle issues of gender violence and racial abuse. It also acknowledged the over-reliance on medication by the medical professional, the need for more access to 'talking therapies' and advocacy services, and a commitment to women-only community day centres, crisis houses and in-patient, secure and other residential settings.

SBS responded to the consultation in 2003, generally welcoming its wide ranging approach and suggestions for reform. However, SBS argued that the strategy had failed to provide more specific information and recommendations on the needs of BME women subjected to abuse. We felt that the strategy had to acknowledge that South Asian women, in particular, had a disproportionate rate of suicide and self-harm connected to experience of abuse, and that they, along with other BME women with mental health problems have extra obstacles within and outside the community to overcome when escaping abuse. These obstacles included strong religious and cultures pressures, racism and discrimination. SBS recommended specialist counselling as well as social care and safe housing services for BME women to improve the situation (See Recommendations for more information).

In 2003, in its implementation guide[12], the DH also advocate a 'whole systems' approach to delivering the women's mental health strategy. The guide identifies BME women and those experiencing domestic and sexual violence as specific groups which need targeted services. It also called for routine screening of domestic violence in the health service. But little of this has been implemented.

Victims of Violence and Abuse Prevention Programme (VVAPP)

The VVAPP[13] was established in April 2004 by the DH using the 'whole systems ' approach to examine the effect of domestic and sexual violence on the physical and mental health of children and adults. It aimed to develop national service guidelines based

on research conducted by the programme. It is one of the few mainstream programmes which targets BME women experiencing domestic and sexual violence. Although there has been some work on childhood sexual abuse, the programme is not yet fully implemented.

Framework for Violence and Abuse Prevention

In 2008, the DH consulted on a *Framework for Violence and Abuse Prevention*,[14] a policy framework which provides an ecological[15] theoretical framework for addressing violence and abuse as a public health issue. However, this has been heavily criticised by women's groups for medicalising women's experience of abuse and ill heath, and perpetrator behaviour, and for supporting disputed 'cycles of abuse' theories, which are regarded by many as simplistic and deterministic. It lacks a gender analysis, says little about the needs of BME women and fails to understand that certain 'treatments' or solutions are ineffective and even dangerous in cases of domestic violence, such as couple counselling and Family Intervention Programmes[16] which involve victims having contact with perpetrators.

National Suicide Prevention Strategy

In addition to the above initiatives on mental health, other relevant DH initiatives include the national suicide prevention strategy, launched in September 2002.[17] The need for the strategy arose from the statistics: there is one suicide every two hours, on average, in England which amounts to around 5000 people every year. Suicide is the commonest cause of death in men under 35 and the main cause of premature death in people with mental illness. The strategy aims at reducing the rate of suicide by 20 per cent by the year 2010. It recognises that the responsibility of suicide prevention is not exclusively that of health services alone and that three quarters of people who commit suicide are not in contact with mental health services.

The strategy has six goals, which are:

1. To reduce risk in key high risk groups
2. To promote mental well-being in the wider population
3. To reduce the availability and lethality of suicide methods
4. To improve the reporting of suicide behaviour in the media
5. To promote research on suicide and suicide prevention
6. To improve monitoring of progress towards the 'Saving Lives: Our Healthier Nation ' target to reduce suicide

The strategy places the need to tackle suicide amongst Asian female survivors of abuse under goal 2 where they do` not receive the same attention as they would have under goal 1. Research evidence suggests that Asian women are a high risk group, and therefore should be targeted under goal 1, particularly as many BME women are unknown to mental health services and resources are required to improve their access to these and other services, such as those on domestic violence. Even in areas such as Southall, local suicide prevention strategies have focused on the needs of men despite the fact that there is a large Asian population in the area and a

number of suicides by Asian women linked to domestic violence. Local research has also shown a higher rate of attempted suicide and self-harm amongst Asian women compared to women in other ethnic groups (see chapter 3).

Media reports have also suggested that a high number of Asian women are using the railway route from Paddington to Slough passing through Southall to commit suicide[18], which has an abnormally high fatality rate (80 out of 240 nationally in 2006). While the figures for Asian female fatalities on this train route have been disputed by Network Rail, they admit there is a high overall rate of fatality incidents which they are attempting to reduce by erecting barriers and taking other measures at Southall and other train stations on the route. While SBS has not noticed a high incidence of suicide by Asian women using local train tracks, it is difficult to assess the overall situation as ethnicity or gender of fatalities are not recorded by the railway company, and the health authority and coroners' courts only keep records of victims resident in the local area. More centralised race and gender monitoring needs to be developed in order to assess the methods used by Asian and other BME women to commit suicide in order to meet the requirements of goal 3 of the suicide prevention strategy.

Self-harm inquiry, therapies and guidance

In October 2007, the DH announced a £170 million boost to expand mental health psychological therapies. This programme appears to have been motivated by the need to save money as mental health problems account for 40 per cent of the numbers claiming Incapacity Benefit, and treating them is estimated as taking a third of GPs' time.[19] However, this programme is limited to Cognitive Behaviour Therapy, and does not undertake longer-term therapeutic intervention, often required in the treatment of conditions such as Post Traumatic Stress Disorder experienced by many BME women escaping domestic violence. The programme needs to be expanded to include these therapies.

Clinical guidelines on self-harm[20] published by the National Institute for Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health, and other projects such as the National Suicide Inquiry into Self-harm among Young People[21] by the Mental Health Foundation and Camelot Foundation are examples of initiatives targeting self-harm. While some of these acknowledge the impact of domestic violence on women in BME communities, recommendations and guidance need to be further developed to meet the specific needs of BME women. Other examples of useful initiatives, which need updating and/or be more inclusive of BME women's issues, is the Royal College of Psychiatrists' guidelines on domestic violence[22] and Department of Health guides and training manuals on domestic violence.[23] However, a new toolkit on children and domestic violence by the DH was published in 2009, which covers some issues impacting on BME children such as forced marriage and FGM.[24]

Department of Health Taskforce on the Health Aspects of Violence Against Women and Children

In May 2009, DH announced a Taskforce to review health aspects of violence against women and girls (later changed from 'girls' to 'children'). The Taskforce was established following criticism in a Home Office consultation on violence against women and girls that the NHS could do better in addressing this problem[25] and by other bodies such as the Home Affairs Select Committee[26] (see 'Introduction' on the comments of the Select Committee in 2008). The Taskforce aimed to identify and improve the NHS response to violence against women and girls in terms of prevention, early intervention and treatment. It also aimed to improve partnership working between local agencies and examined a range of issues including domestic violence and harmful traditional practices.

In its interim report published in November 2009[27], the Taskforce stated that there was a need for increased awareness of and information on services in relation to violence against women, including issues such as harmful traditional practices. There was an acknowledgement that health workers were not implementing routine enquiries on domestic violence, which had been rolled out through antenatal and mental health services, as staff were unaware of how to advise victims and where to refer them. Victims also reported that they did not disclose abuse because they were not given the opportunity to disclose. Others said that they attempted to disclose but were not believed or received an unsympathetic response.

The Taskforce recommended improved local care pathways, particularly for adults as safeguarding routes for children were already in place, and would examine the need for advocates as suggested by victims, particularly for those who could not speak English or were subject to the 'no recourse to public funds'[28] requirement. The lack of interpreters was recognised as a problem. Victims also reported that specialist third sector services providing advocacy and counselling, particularly women-only services, were a lifeline. The Taskforce stated that it will publish commissioning guidance for services to reflect local need, particularly in relation to minority groups.

In March 2010, the Taskforce published its final report, *Responding to violence against women and children – the role of the NHS,* [29] together with reports of its various sub-groups and focus groups. The Taskforce chair, Professor Sir George Alberti, stated in his introduction: *'it is a disgrace that so little has been done by the NHS so far. I urge the Government not only to accept the report but also to implement the recommendations as a matter of urgency.'* The report recommends that violence against women and children should be tackled within the NHS on the same basis as other areas of NHS work, such as diabetes and stroke. This includes increased awareness, training and education of staff to support women and children as well as improved data collection, information sharing, commissioning criteria and referral pathways between statutory and voluntary sectors.

With respect to BME women and

children, the Taskforce recommended that appropriate services are available and targeted questioning should exist within the NHS on female genital mutilation (FGM) for communities where the practise exists as part of an integrated local pathway of care for FGM. It also recommended that interpretation services should ensure that abuse is disclosed confidently and confidentially, and that direct treatment should be available to women and children experiencing abuse regardless of their immigration status. The sub-group working on harmful traditional practices (HTP) and human trafficking added more proposals specifically in relation to HTP: that there should be risk assessment procedures to improve patient and staff safety in hospitals and safe information sharing; that guidance and indicators are developed or more effectively utilised; that evidenced specialist psychological treatments, including those based in the third sector, should be available; and that independent specialist BME women's advocacy services should be commissioned. This sub-group specifically mentioned the work of Southall Black Sisters as an example of best practice[30] as did the women's focus group report.[31] The domestic violence sub-group echoed some of the recommendations made by these groups.[32]

In an interim response to the Taskforce report, the DH accepted many of the recommendations in principle, but said little about how it will ensure that the needs of BME women are fully addressed or integrated. It also specifically stated that free health care for direct services for those with immigration problems will be difficult to introduce, but needs further consideration.[33] It reported that the DH already recognises the need to address violence against women and children in their current policy on mental health, *New Horizons*.[34] In addition, it is investing £3 million for 2010/11 in Family Intervention Projects (FIPs), where health services work with social care agencies to assist families from low socio-economic backgrounds to reduce anti-social behaviour, domestic violence and mental health problems.

While the reports of the Taskforce are welcome as they recognise some pertinent issues affecting BME and other women and children facing abuse, and make progressive recommendations, we remain concerned that there are insufficient resources and commitment to implement them as highlighted by the DH's interim response and a poor record in completing other related programmes of work. We are also concerned that FIPs could put women and children at risk of further domestic violence if there is an attempt to work with the whole family, including perpetrators. FIPs have so far mainly worked with predominately white families; the extension of the programme to include BME women and children could put them at increased risk of domestic violence and honour based violence within extended families and tight knit minority communities where there is pressure for women to stay within abusive relationships.

The Mayor of London strategy on violence against women and girls

The Mayor of London also consulted on health issues in relation to his strategy

on violence against women and girls, to which SBS responded. In his final strategy, *The Way Forward,* [35] the Mayor of London made a welcome commitment to meet the needs of diverse communities, including BME women, and called on the London-wide health service to commission specialist provision and extend routine enquiry to a wider range of health settings. It also called for improvements in interpretation services, and homicide reviews to cover suicide cases. Although the strategy does call for government to address problems around immigration, harmful traditional practices and suicide and self-harm, it does not go into detail about how this should be done.

While their focus on violence against women and girls, including that of BME women/girls, is an important move forward, the Taskforce, the DH and the Mayor of London do not go far enough (see Recommendations).

LEGAL AND STATUTORY MECHANISMS

Other legal or statutory mechanisms which handle suicide cases, and thus in a position to aid suicide prevention, include the coroners' courts, homicide reviews, local health authority serious case reviews, and even the criminal courts. These are discussed below.

The coroners' courts

In July 2001, the Home Office began a fundamental review of coroner services. The system was recognised as being archaic. The report of the review, published in June 2003 [36], said:

> *'The systems in England, Wales and Northern Ireland for the certification of most deaths by doctors and the investigation of others by coroners have been seriously neglected over many decades. They must undergo radical change if they are to become fit for the purposes of a modern society and capable of meeting future challenges. The need for reform is widely recognised and supported.'*

In February 2003, SBS made submissions to the review.[37] SBS highlighted the fact that in many cases, BME women were driven to suicide as a result of domestic violence, and that the coroners' courts had a role in investigating this connection and in making recommendations for action by public bodies in order to prevent future fatalities. It outlined other specific problems, such as, the fact that bereaved people were poorly informed, consulted or supported, following a death and that in many domestic violence cases, the next of kin was usually a husband or the perpetrator, which means that the victim's birth family receive less information and support by the police and the coroner's service. In addition, SBS raised concerns about unwillingness on the part of coroners to hear or accept expert evidence in relation to domestic violence and its impact on black and minority women, and their resistance to third party representation. SBS also argued that there should be a strong presumption of holding a public inquest in cases of suicide or suspicious deaths. The case of Nazia Bi highlighted the problem of how the coroner's use of discretion often results in a refusal to hold an inquest, and to accept third party representation mainly out of the desire to appear to be 'culturally sensitive', thus making the system unaccountable to BME women (see chapter 3).

The fundamental review recommended that the coroners service values should aim to:

'Meet public safety, public health, public confidence and human rights requirements for the protection of life throughout all sections of the community without discrimination or favour, with full independence and proper accountability. '

The fundamental review made several other positive recommendations: it argued for a Family Charter to improve the rights of families, including access to greater information and support; extending the range of people who can make a referral to the coroners in a death involving an unresolved concern or suspicion including any member of the family or public or a professional body; and a stronger bias towards more narrative and analytical reports and preventive findings. The coroners' service should aim, 'To contribute along with other public services and agencies to the avoidance of preventable deaths.'

However, the review also found that, 'There has been no reliable or systematic response to minority community wishes, traditions and religious beliefs.'

While it is important to respect the wishes of the bereaved family and their traditions and beliefs, sometimes this has been used by families within minority communities to prevent a proper inquest into deaths of minority women. Coroners have felt under pressure to speed up the process of investigation to accommodate religious rituals and practices or even not to hold an inquest altogether.

The review also said that death by suicide should not automatically qualify for a public inquest, unless:

'There are grounds to examine whether there had been any third party involvement in the death...or where the circumstances which may have led to the death are reflective of a pattern of similar circumstances (such as allegations of coercive domestic pressures) which might benefit from public examination and, possibly, recommendations for future preventive strategies. '

While this acknowledgment of the need to uncover issues connected with domestic violence is welcome, there is tension between the family or community attempts to cover up domestic violence and women's groups to uncover it especially where women may not have made reports to outside agencies and where questions arise as to what serves the public interest. Religious (where suicide is often regarded as a sin) and cultural reasons can be used to prevent a full investigation. Thus crucially, the review failed to appreciate that unless all suicides were subject to public scrutiny, the existence of such abuse may not be revealed. The review also failed to appreciate that third party interventions should be supported in order to allow the public to raise questions which the family or the community may refuse to do. As the review itself acknowledges, an inquest, *'(...) has a role in enabling the family and the public to find out what 'what happened... '*

The review only slightly extended the scope of the inquest to deal with 'sequence of causality, ' and recommended that:

'Decisions on scope should be taken by the coroner in the light of the circumstances, after considering any submissions from the family or other participants. Long-term or speculative issues should be excluded.'

Despite the limitations on public inquests and examination of causation issues, the review nevertheless recognised the need for better statistical information in order to meet government targets for reducing suicide, and recommended monitoring of ethnicity:

'Data of this kind would enable suicide prevention campaigns to be better targeted...there are grounds to think that suicide rates amongst young Asian women may be abnormally high, but without good ethnicity data well-founded preventive action is hard to design.'

However, by failing to examine more thoroughly the causal or contributory factors such as domestic violence in inquests, these monitoring systems would fail to make these campaigns sufficiently targeted to tackle underlying causes of suicide amongst BME women.

In March 2004, the Home Office published its response to the review in a position paper[38]. It stated that the Government intended to introduce a more 'robust' coroner service, *'The product of the inquest would be more clearly focused on the need to learn lessons and to avoid preventable deaths.'* The Home Office agreed with the need for a family charter and added that:

'The family charter will recognise the needs of all communities, including the particular sensitivities of some faiths and individual families. These needs will be respected as far as is consistent with the social obligation to undertake a thorough investigation of individual deaths in certain circumstances.'

The Home Office stated that coroners should have 'local knowledge and sensitivity to the needs of the community', and supported narrative verdicts and public inquests in all unnatural deaths, providing an essential safeguard and public scrutiny. However, in February 2006, the Department of Constitutional Affairs (DCA) issued a briefing note[39] which announced that in specific cases, such as some suicides and child deaths, coroners will have a new discretion not to hold public inquests where no public interest would be served. In these cases, the coroner will investigate the death and publish a report. In January 2007, the Government also announced its intention to place a legal duty on public bodies to respond to Coroners' findings, to reduce public inquests and inquests with a jury in its Coroners' bill.[40]

The Coroners and Justice Act 2009 removed the proposal that some inquests will not be held in public (except those subject to the Inquiries Act 2005) and improved the requirement on coroners to make recommendations to public bodies. However, there is still no mandatory requirement on public bodies to implement these recommendations or a mechanism to ensure they do so. There are also a number of other ongoing concerns including: the need to widen the scope of an inquest so that the history of domestic violence is properly understood as a causative or contributory factor in suicides; the coroner's discretion not to hold an inquest should not apply where there are outstanding issues of public concern and obligations under

the Human Rights Act; the acceptance and use of expert evidence; the right to third party interventions; and improved access to public funding for families needing legal representation at inquest. It also appears that ethnic monitoring has not been introduced as recommended by the coroner's review. Such monitoring should be implemented, centralised, and extended to include a breakdown of suicide cases by gender, ethnicity and domestic violence issues. In their consultation with bereaved families, the DCA found that that there was considerable support to ensure that the scope of an inquest should be wider than solely ascertaining the reasons for the individual's death, and that recommendations made by the coroner are acted upon. As one participant said, *'The key, the main focus, the key end should be to prevent the next death. '*[41] (See 'Recommendations').

Homicide reviews

In February 2006, in response to a parliamentary question by Anne Snelgrove MP on the murder of Julia Pemberton and her son, William, by her abusive husband in November 2003, Harriet Harman stated that homicide reviews 'sprung up because the coroner system has not been dealing appropriately with these cases' and, 'if the coroners' system were working properly, we would not need homicide reviews'.[42]

In June 2006, the Home Office issued its consultation paper on homicide reviews[43]. The Domestic Violence, Crime and Victims Act 2004 made it statutory for local bodies to establish homicide reviews for victims of domestic violence aiming to identify 'lessons to be learnt ' from the death of an adult over 16 years old in a domestic violence context. They are 'not enquiries into how the victim died or who is culpable. This is a matter for coroners and criminal courts ', and will have a 'no fault' approach to aid 'truth telling'. Although not within the terms of the Act or governed by guidance or another statute, the Home Office suggested that local agencies may also carry out a review in cases of suicide that are related to domestic violence. SBS, expressed a concern that the homicide reviews, as proposed in the consultation paper, had major problems. It argued:

'Our fear is that the focus of homicide reviews will be very much on preventative accountability which will bypass the need for agencies to publicly acknowledge their duty to protect and to account for that duty. We also fear that due to lack of funding and expertise, homicide reviews will vary in quality across the UK. Local reviews may suffer from the lack of a proper in-depth review, be poorly led, and the implementation of recommendations may be severely hampered. It has already been explicitly stated that the costs of the reviews would be absorbed into the daily working routines of the relevant agencies,[44] *which in our view, are severely under-resourced. Moreover, any recommendations made are likely to remain local and internal to the relevant agencies and may not have an impact at a national level to ensure consistency of policy and practice across the UK. Even though it is envisaged that the final report of the review is sent to the relevant government department, there is no mechanism for*

ensuring that the government carries out any necessary reforms…

We fear that not all homicides and suicides will be investigated and the review will be seen as replacing the need for public processes (inquests) into the murders of women. Another concern is that many of the recommendations made in the course of conducting such reviews will not be implemented due to a lack of political will. What is needed is not report after report, but action based on those reports. These criticisms are substantial and lead us to reject the proposed homicide reviews as the main forum for investigation of domestic violence related deaths. In the light of the limitations of the police complaints system and the resounding failure of the coronial system to conduct effective investigations into domestic violence related deaths, we fear that the opportunity to ensure that homicide reviews meet the State's human rights obligations under the Human Rights Act, by addressing both institutional and individual accountability, has been lost.'[45]

Despite these misgivings, SBS made a number of recommendations to improve the effectiveness of homicide reviews, such as the need for greater independent scrutiny, as they may help to prevent some deaths by identifying gaps in the system, but added:

'However, we would maintain that homicide reviews should be seen as only one of a number of forums for the investigation into the domestic violence related deaths. It should not seek to replace either inquests or the complaints system since those forums have the potential to provide institutional and individual accountability. '[46]

Since their introduction, SBS has only participated in one homicide review, and are unaware of such a review being conducted in a case of suicide. We continue to have a number of concerns about the effectiveness of homicide reviews, particularly in relation to lack of independent scrutiny which prevents a thorough examination of the issues. Agencies are reluctant to fully participate or highlight shortcomings, and although there is a Home Office and a London based working group on homicide reviews, there appears to be little sharing of 'lessons learnt' at the national level or effective implementation of recommendations in local areas.

Serious case reviews

The homicide reviews are designed to complement the existing serious case reviews that take place when a child dies. SBS's experience of serious case reviews is that they often ignore the role domestic violence played in the case, as illustrated by the cases of 'Aisha' and 'Sonia' (see chapter 3). Therefore few, if any, 'lessons' are learnt about preventing future child fatalities linked to domestic violence.

Criminal courts

For some time, SBS has argued that some suicide cases should be subject to criminal prosecution. In May 1996, SBS made submissions [47] to the Law Commission, which consulted on a proposed new Homicide Act,[48] to give urgent consideration to the possibility of the creation of a specific homicide offence to cover cases where suicide has been aggravated by domestic violence or

oppressive conduct. SBS emphasised the point that the aim in seeking the creation of a new homicide offence in such cases is not to make it easier to undermine the sound principles upon which all prosecutions for criminal offences should proceed, namely the need for certainty and fairness, but rather the aim is to ensure that the UK meets its obligations under Article 2 of the ECHR. In particular, to ensure that appropriate criminal law provisions are in place to deter and prevent the commission of offences so that the life of those in this jurisdiction, especially those who are vulnerable, is safeguarded.

The idea for a specific homicide offence arose out of the case of Gurjit Dhaliwal, (Box 3), where the Crown made an unsuccessful attempt to prosecute her husband for manslaughter following her suicide after suffering domestic violence.

SBS advised the Crown Prosecution Service about the relevant social and cultural context to the case. In our submission, we stated that in the case of Gurjit Dhaliwal, the police brought manslaughter proceedings as well as charges of inflicting grievous bodily harm against the husband. The Crown Prosecution Service took the view that although there were some assaults experienced by Gurjit, including on the day of the suicide itself, they would not be able to establish a causal connection between the assaults and the suicide. Instead they decided to focus on the psychological injury suffered by Gurjit as a result of the whole pattern of domestic violence. They argued that the psychological injury amounted to grievous bodily harm; that Gurjit's husband was guilty of inflicting psychological injury which played a significant part in causing Gurjit to decide to end her life.

At the hearing, held in March 2006, the trial judge took the view that although the facts of the case established that the husband did conduct himself in a way that was reprehensible, few of his acts amounted to unlawful conduct. In the absence of a consensus amongst psychiatrists as to whether Gurjit suffered from a recognised psychiatric illness, the court found it difficult to accept that psychological injury

BOX 3

On the evening of 22 February 2005, Gurjit committed suicide by hanging herself in an outhouse at the back of her home in Southall.

After her death, considerable evidence, in the form of a diary, witness statements, court injunctions, police reports and medical reports emerged, showing a history of domestic violence: she had suffered psychological abuse as well as some physical assaults. In August 2004, she had also been admitted to hospital having consumed a large amount of alcohol and having tried to slash her wrists. She was recorded as having 'family' problems.

On the day that she committed suicide, Gurjit had an argument with her husband and he had struck her on the forehead. The kara (religious Sikh bangle) he was wearing at the time cut her skin at the point where the blow landed.

could amount to bodily harm. The court asserted that all that could be safely said was that Gurjit suffered from a psychiatric or psychological injury. The court concluded that 'there is no basis on which a reasonable jury, properly directed as to the law, could convict.' So the case was dismissed and a verdict of 'not guilty' entered against the husband. This ruling was upheld by the Court of Appeal later that year.

The hearing was bogged down with the question of whether psychological harm amounted to bodily harm. Distress, grief, helplessness, fear and panic amongst other psychological symptoms, were not considered to be recognisable symptoms of psychiatric illness and therefore incapable of fitting the definition of bodily harm. However, many of these symptoms are cited in cases of the battered woman syndrome or post traumatic stress is invoked in cases of abused women who kill.

SBS agreed with the presiding judge that a better approach would have been to argue that when viewed in the wider context of the domestic violence and abuse that Gurjit experienced, the last assault upon her was the final unlawful act which triggered her suicide. The Judge indicated that such an approach would perhaps have been more readily accommodated within the present framework of unlawful act manslaughter.[49]

However, there are a number of problems even with this approach. From the comments made by the judges, it is possible that in cases where the triggering act is not a physical assault, it will not be deemed to be unlawful. This is highly unsatisfactory since conduct which amounts to harassment, would fall outside the scope of unlawful act manslaughter. Yet elsewhere in criminal law, harassment is perceived as an unlawful act. Whilst prosecution can only proceed if there is a sound evidential basis, any act of harassment which may have a cumulative effect will be discounted as the final trigger that results in suicide. Also, in such cases, there is a question as to whether causation – a direct link between the final assault and the suicide, can be established as any significant time lapse between an assault, even if it occurs in a wider context of harassment, and the suicide will make it difficult to bring a prosecution of unlawful act manslaughter. Finally, if a conduct of domestic violence or abuse results in psychological harm, however serious that may be, rather than psychiatric harm, there can be no basis upon which to bring a criminal prosecution under the present law on manslaughter.

'(...) there may be cases, where a decision to commit suicide has been triggered by a physical assault which represents the culmination of a course of abusive conduct. I do not see any reason in principle why the final assault which triggers the suicide should be looked at in isolation. If a defendant by his previous conduct has reduced the victim to a psychological state in which the 'last straw which broke the camel's back is liable to tip her (or him) over the edge, I would have thought there was some force in the argument that the last straw played a significant part in causing the death'[50]

Given the difficulties in bringing a successful prosecution within the present framework of homicide laws, there is concern that in cases where domestic violence or oppressive conduct is the direct or a significant contributory factor in a

suicide, no public condemnation is brought to bear on those culpable. Whether a course of conduct results in physical, psychiatric or psychological harm (signified by amongst other things, the symptoms of fear, distress, helplessness and suicidal thoughts) there has to be some means of ensuring that those responsible for causing someone to take their life, are held criminally liable. The current state of affairs in untenable; indeed, in the case of Gurjit Dhaliwal, the court itself recognised this when it observed that [51] :

'It is impossible not to have sympathy with the point of view ... that some kinds of psychological harm can have consequences just as severe as those of some kinds of recognised illness, and that liability to a conviction for manslaughter ought not really to depend (as it does in the current state of the law) on whether the victim's condition can be brought within one of the recognised categories of psychiatric illness.'

The new offence of homicide proposed by SBS, 'Constructive manslaughter/Suicide aggravated by harassment or violence' would apply thus:

'Where a course of harassment or violence causes a person serious physical, psychiatric or psychological harm that directly results in a suicide or is a significant contributory factor in the suicide, the offender shall be guilty of constructive manslaughter/causing suicide aggravated by harassment or violence.'

The SBS proposal refers to harassment rather than domestic violence because harassment is already defined as unlawful in, for example, the Protection from Harassment Act 1997. The use of the concept encompasses a range of oppressive behaviour such as racial harassment and violence.

The Harassment Act provides a basis for developing a new homicide offence. Under the Harassment Act, it is already a criminal offence to cause harassment, alarm or distress by a course of conduct on more than one occasion. The conduct need not be the same on each occasion, need not be directed against the same person and can include speech – which the alleged offender knows, or ought to know, amounts to harassment of the other. Under the Act, it is also a criminal offence to cause fear of violence which must be caused on at least two occasions. The fear of violence must be caused by a course of conduct and the alleged offender must know or ought to know that the course of conduct will cause the other to fear violence. It should be noted that where harassment or violence leads to an attempted suicide, then that situation would be covered by the existing law, such as section 20 of the Offences Against the Persons Act 1861.

In a separate initiative in October 2006, Iain Duncan Smith MP attempted to introduce a private member's bill on criminal liability for suicide. He made the connection between domestic violence and suicide: [52]

Surely there is hardly anybody in this Chamber or among the general public who has not long believed that there are often connections between suicide and things that have gone on before.

The Dhaliwal case has also led to a circular being issued to the coroners'

courts informing them about the new legal developments where suicides involving domestic violence may be liable to criminal prosecution.

Voluntary sector and community based initiatives

Most mental health voluntary and community sector initiatives are focused on generic issues (see Appendices 1 and 2). While some target the mental health needs of specific ethnic and/or gender groups, very few target the specific needs of BME women experiencing domestic violence. The SBS Project is one of the few initiatives which have a high success rate in tackling domestic violence and mental health problems among BME women, and need to be expanded and replicated in order to improve service provision for this disadvantaged group. Another similar project, Zindaagi which is based at Newham Asian Women's Project, provides therapeutic and social support group activities linked to advice and refuge services for Asian women who have experienced domestic violence. It has also produced research and other material, and undertaken local development work with practitioners, such as the East London Self-harm Forum. They report positive outcomes in providing holistic services combining counselling with mental health and welfare work.

Some second tier domestic violence agencies which have considered the needs of BME women include the Greater London Violence Project (now re-named Against Violence and Abuse – AVA) which provides training and a 'toolkit' for mental health workers on women and domestic violence, and Women's Aid which has undertaken policy work and provided guidance on the issue. However, most frontline domestic violence service providers lack the resources to provide high support refuges and in-house counselling for women with mental health problems. This is even more so in the case of BME women.

Most mental health services in the voluntary sector also lack resources and the expertise to deal with the complex needs of BME women experiencing domestic violence and mental health problems. Although there are some BME based mental health services such as Nafsiyat Intercultural Therapy Centre, in North London, and counselling services, specifically for women, such as the Women and Girls Network in West London, there are hardly any specialist counselling or mental health services which meet the therapeutic or mental health needs of BME women. The few that exist include projects such as Pukaar,[53] a counselling service for Asian women in West London (which has also produced a useful toolkit on domestic violence and mental health problems among Asian women), and FORWARD and Akina Mama Wa Afrika which undertake work on FGM or health issues for African women. They also make referrals to domestic violence organisations for refuge and other support for their clients. There is also some specialist provision on FGM within the NHS, but these are increasingly threatened with closure or reduced services as a result of mainstreaming or funding cuts as highlighted by the case of the Waltham Forest Primary Care Trust African Well Women's Clinic.[54]

However, the need for holistic services is highlighted by this and other research, where survivors often regard specialist services for BME women as 'home from home'. For example, a Manchester based study on suicide and self-harm amongst Asian women concluded that: *'..service interventions which engage both with the practical (e.g. safety, housing, benefits etc.) as well as emotional support are well received by survivors'.*[55]

More initiatives in the community should be developed in order to prevent mental illness, suicide and self-harm, including awareness raising campaigns to inform BME women about their rights and to improve access to services to enable them to escape abuse and to deal with trauma. In addition, community initiatives should challenge social, cultural and religious attitudes and values about traditional gender roles, domestic violence, notions of shame and honour and the stigma of mental illness, and aim to empower women by eradicating gender inequality. One example of community based initiatives is in a girl's school near Southall where a school counsellor is raising awareness and working with predominantly South Asian pupils to prevent and treat self-harming behaviour. Care, however, should be taken that community initiatives do not reinforce conservative cultural and religious values, and the use of faith-based groups and community leaders, who have a history of adhering to and promoting such values, is not encouraged. Rather, the emphasis should be in supporting secular BME women's organisations with a track record of challenging domestic violence and conservative value systems, ensuring they are fully funded and consulted to lead campaigns and initiatives within the community.

In conclusion, there are very few mainstream or voluntary and community sector initiatives which target the mental health needs of BME women experiencing domestic violence. Those which do exist are under-resourced. This is in a context where neither professionals nor the more powerful institutions within BME communities are tackling the problem effectively or appropriately. The need to invest in frontline secular, specialist, BME women's services is crucial. There is also a need to challenge social, cultural and religious values and perceptions within minority communities which stigmatise mentally ill women and those who question or leave abusive situations. Equally, there is an urgent need to reform social policy and best practice to improve the State's response to the needs of BME women experiencing domestic violence and mental health problems in order to fulfil its human rights obligations with due diligence.

EVALUATION

THE SBS MODEL

The SBS Domestic Violence and Mental Health Project is a holistic model which combines advice and advocacy, group support activities with counselling and psychotherapy services for BME women experiencing domestic violence and mental health problems. The aim of the Project is to reduce the incidence of mental breakdown, suicide and self-harm by ensuring women are assisted to escape domestic violence and to prevent or overcome the trauma of abuse through specialist therapeutic intervention reflecting the race and gender needs of BME women.

The elements of the SBS model are:

- Information, advice, advocacy, befriending and support services on domestic violence and mental health, including suicide and self-harm (see chapters 1 and 3).
- Counselling and psychotherapy services based on a new hybrid model (see chapter 2).
- Advocacy or policy and research work to create social change and (see chapter 4 and appendices 1 and 2).

Project outcomes

The Project was monitored and evaluated internally by SBS, and found to have a high success rate. The audit criteria measured the following:

- The extent to which service users felt safe and were safer.
- The extent to which services users felt better informed and enabled to access services and their rights.
- The extent to which service users resolved their social problems, namely domestic violence and related issues.
- The extent to which service users felt less depressed, thus reducing mental breakdown, self-harm, suicide attempts and ideation.
- The extent to which service users led independent lives free from domestic violence and mental health problems.
- The extent to which other agencies consulted SBS and used its expertise to influence their policies and practice.

Performance indicators include:

- Number of cases and enquiries the Project handled.
- The number of issues or problems which were resolved or had successful outcomes e.g. women entering refuges or safe permanent accommodation, women obtaining their immigration status or civil court injunctions etc.
- The number of women who made a recovery or improved their mental health by becoming more self-confident with a positive outlook, and reduced self-harming behaviour, suicidal thoughts and medication through the counselling and psychotherapy services.
- The number of agencies which contact SBS for specialist consultation and respond to its advice.

- The level at which service users rate the service.
- The number of service users who feel safer and more informed about choices, able to access services and lead independent lives.

The success of the model is measured by the following outputs and outcomes:

1. High number of cases and enquires dealing with 6,485 issues between 1 April 2001 to 31 March 2009, which nearly tripled over eight years, indicating a high and increasing demand on the Project from service users and agencies alike
2. 3,380 BME women used the service over a eight year period (2001/2009)
3. Eighty two per cent of cases in the sample of 89 women provided with casework support by the Project from 1 April 2001 to 31 March 2009 had successful outcomes, while four per cent were unsuccessful, six per cent had unknown outcomes and eight per cent had outcomes pending. Only one percent of this sample were subjected to repeat victimisation
4. Domestic violence, mental health and immigration/asylum cases taken to completion had a 100 per cent success rate which meant that victims were not deported or removed from the UK
5. SBS has dealt with 18 suicides or deaths due to unknown causes since 1979, eight of which were referred to SBS, following death, between April 2001 and March 2009. There are no other domestic violence organisations providing specialist help on BME women and suicide cases, and the Project therefore has a unique expertise.
6. Seventy two per cent of the cases (13 out of 18) of suicides were taken through the inquest process with the assistance or involvement of SBS in order to determine what happened and to raise issues of public interest to prevent future fatalities. SBS was successful in raising issues of domestic violence in all cases, but the verdict did not always reflect the fact that domestic violence was a causal or contributory factor. However, a precedent was set in one case where the coroner's verdict recognised the causal link between suicide and the insecure immigration status of an Asian woman experiencing 'marriage difficulties'. In another case, the coroner's preamble to a verdict of suicide recognised the impact of cultural pressures resulting from living with in-laws. In addition, although unsuccessful as it did not proceed to full trial, SBS advised on the first case involving domestic violence and suicide to be prosecuted for manslaughter. SBS was also the first domestic violence organisation to legally challenge a coroner's decision not to proceed with an inquest for fear of being 'culturally insensitive'. These cases set important legal precedents (see chapter 3)
7. The high number of participants in support group activities, which ranged from 8-100 women and children (mental health cases are part of the wider group) depending on the type or scale

of the activity. On average, eight women regularly attended weekly support group activities and the annual residential for the Project

8. The high number of women using the counselling services. Fifty women have received counselling services over a four year period (2002/6), and an additional 34 for another three years (2006/9). There are 8-10 women in counselling and a waiting list of 12 women at any one time. Counselling lasts 12-26 weeks per client
9. Ninety four per cent of women (47 out of 50 women over a four year period 2002/6) were successful in overcoming trauma following counselling/ psychotherapy and group therapy, thus reducing reliance on medication and reducing suicidal and self-harming behaviour Only six per cent (3 out of 50) were unsuccessful, mainly because the cases were complicated by alcohol addiction or a severe mental disorder. An increased number, ninety six per cent of women, had successful outcomes between 2006/9.
10. The Project helped to refine Shahrukh Husain's new hybrid model of counselling and psychotherapy taking into account the race and gender dimensions of BME women's experiences of domestic violence, which will help to influence medical practice and develop diagnostic criteria for PTSD.
11. The project had a high impact on policy and practice as indicated by SBS involvement in the DH Victims of Violence and Abuse Prevention Programme and success in other initiatives: some recommendations made by SBS to the Coroners Review (e.g. that the coroners' courts need to monitor cases by ethnicity to deal with abnormal rates of suicide amongst Asian women) and the Women's Mental Health Strategy (e.g. that there is a need for more targeted services for BME women) were accepted. Also, the Project ensured that the DH Taskforce on the Health Aspects of Violence against Women and Children 2010 accepted a number of our recommendations and recognised SBS as a good practice model.
12. The Project collected information from other agencies through a ground breaking survey and a consultation exercise (Appendices 1 and 2) which helped to compare and contrast different BME women's experiences and needs, and which informed our assessment and recommendations.
13. Service users expressed a 93 per cent satisfaction rate (see below).

Feedback

As part of the evaluation of the Project, SBS interviewed a sample of 15 service users about the effectiveness of its work. It also received informal feedback from agencies and other service users. Five women were also interviewed for the DH Victims' Pathways project in the Victims of Violence and Abuse Prevention Programme in 2007, and 12 women participated in the DH Taskforce focus group in 2009. Survivors also participated in the SBS conferences, seminars and focus groups.

Fourteen out of 15 service users, who were interviewed, rated the services as very good to excellent. They felt better informed of their options and rights, more supported, safer and less depressed. One service user said that the counselling services did not help to deal with all her problems.

The following comments about the SBS project since its inception in 2001 were made by different service users. They emphasise the effectiveness, usefulness and significance of the project. Service users often state the importance of trust: that the counsellor and the Project Worker or advocates will not break their confidence, and that they will be understood – culturally and emotionally:

'Southall Black Sisters always has empathy and is willing to help with solutions. There is always a solution at the end of the conversation. No matter how busy they are, they always give quality time and the sheer dedication shows. I could have ended my life because I felt so hopeless, but your help has made all the difference.' (Sheila)

'I approached Southall Black Sisters for advice and advocacy and have been receiving help from this organisation ever since. I am currently receiving counselling at the centre on a weekly basis. I find these sessions very important because they are effective.

Soon after the death of my mother, I began counselling with a different organisation, but stopped after just two sessions as I didn't find them very useful. These sessions have enabled me to function better as a person and to alleviate some elements of my depression, and I would find it extremely difficult to find another therapist who I can engage with as well as this.

The therapist I am working with also understands my cultural background very well and this is another reason I want to continue having counselling at Southall Black Sisters.' Sadhana

'The days I have spent here are the happiest and most amazing since I arrived in this country. I will remember them for the rest of my life.' Ravi (support group member on a residential)

'I stopped thinking about attempting suicide after seeking help from SBS and its counselling. They gave me the needed strength.' Mumtaz (service user)

'I felt myself very lucky getting the opportunity to go to Cornwell with SBS. I had not seen such a place before. It was very exciting. The company of women from different communities made great changes to my life. Every moment was very enjoyable. It made me feel relaxed. When I remember the trip, it makes me forget all my problems.' Nilaben (support group member on a residential)

'The Project Worker talked and communicated with me, and created a friendly environment with the support groups where I have made new friends. This service is important for women who do not read or write English. They also give advice on issues I need help on, like my asylum problem. I was depressed because the Home Office was not giving me asylum and because I have gone through rape and other tortures in Somalia. The counselling also helps with all of this.

The counsellor understands my cultural and religious background and so there is less room for misinterpretation or lack of understanding than with other counsellors. I did go to my GP, but I had to wait too long to see a psychiatrist. I was on anti-depressants, but I found that talking helped. I did not like the drugs because they made me sleepy and caused pain in my muscles, but I am no longer on medication. The counselling and support at SBS has helped me to recover, although I still worry about my asylum problem and the future.' Naila

'Your help has been very useful. Things I was not able to talk about before, I can now talk about. I had lost a lot of trust in people. You have helped me to overcome this. I thought all men are the same, but the counselling helped me to change this view. I had a lot of anger in me, and I was on anti-depressants, but now I do not need this.' Roopinder

'I did not realise that it was possible for anyone to help, and listen to my problems. I was very worried. My solicitor referred me to SBS. I did not myself realise that organisations such as SBS existed. The Project Worker helped to sort everything out.

I was very confused and I was not sure about talking to a counsellor. I thought she may tell other people in the community about me. But I felt alone and talking helped. I was soon able to tell the counsellor about all my problems. I could speak openly to her. She reassured me that she will not break my confidence and she didn't. I had to leave counselling because I got a job and could not find the time to attend. But counselling has helped me to feel better.

Before I would get frightened and begin to cry when dealing with difficult people or situations, but now I feel more confident and able to deal with the problems. My GP did not give much help and did not understand my cultural background like the SBS counsellor does. The counsellor understands how izzat (honour) affects me. People think the divorce was my fault. No one understood my feelings until I came here.' Rukhsana

The following quotations are positive comments about the SBS Project made by agencies:

'Southall Black Sisters' in-house therapy work is just fantastic, and I am sure if you ask women where they would rather be, SBS, their doctor's surgery or a hospital? I can guess what they are going to say.'

'As a solicitor, I could not have done any legal work with my client because of her mental health problem without your Project's involvement. You have made all the difference in helping her to understand my advice and give instructions, which led to her obtaining indefinite leave to remain in the UK'.

'Our firm has been undertaking human rights work for a number of years. In many cases, especially with bereaved families, access to experts is a real problem. Southall Black Sisters have often provided the only source of help and assistance to families. Their expertise and empathy means that families have confidence in them. Our task in representing bereaved families in the tragic deaths that take place would be impossible without SBS. In addition to their role in helping families, SBS have also provided expert reports to Inquest and other type of cases. More recently, they have bravely challenged by Judicial Review the decision of HM Coroner for West Yorkshire. In that case, Mr Justice Jackson QC held that SBS did have standing to challenge the decision of the Coroner and that they acted in the public interest. That basically sums up SBS, standing up for the most vulnerable in our community and acting in the public interest.'

REPLICATION

The need for the SBS model to be replicated elsewhere, in other parts of Britain, is highlighted by 'Anisha', who received SBS help to escape a forced marriage. In June 2001, she said in her evidence to the United Nations Working Group on Slavery:

'Although I am away from my family now, I have been very depressed ... Although I have friends, I do need more support to deal with what has happened.

Southall Black Sisters are helping me, but there is a need for more organisations like them for advice and counselling in other parts of the country. They are based in London and I now live in the North. I need more help in my local area'.

In March 2010, the DH Taskforce on the Health Aspects of Violence Against Women and Children focus group for survivors and the sub-group on harmful traditional practices and human trafficking

cited SBS as an example of best practice:

> *'The WNC Report [Women's National Commission focus group report] also highlights the work of Southall Black Sisters (SBS) as an example of good practice. SBS, founded in 1979, runs a holistic resource centre providing information, advice, advocacy, counselling, befriending and support services for BME women experiencing gender based violence...it is generally accepted that advocacy/interpretation services and specialist support can be effective or, in some cases, an essential part of care provision. It is self-evident that a victim of honour based violence who is fearful and unable to communicate in English will need support to explain what has happened to her. The work of organisations, such as SBS...can play an important part in helping victims to rebuild their lives.'* [1]

RECOMMENDATIONS

The following recommendations are based on findings of the SBS action-based research, and include the views of survivors and other agencies. BME women survivors should be empowered to lead independent and meaningful lives free from domestic violence and mental health problems by a 'whole systems' approach which improves their access to: counselling or psychotherapy; legal, health, housing, advocacy and social care services; employment; welfare benefits; education; creative and leisure facilities and activities; English language classes and interpretation services; childcare support; secure immigration status and community or civic participation.

SERVICES

1. There should be a localised service which is based on the SBS model in every Primary Care Trust area or equivalent with a high BME population.

2. Agencies should be funded and supported to provide specialist services on domestic violence and mental health for BME women based on the SBS model. This includes combining advice, advocacy, support, befriending services and refuge provision with counselling, psychotherapy and group therapy. These specialist services should be based in the community and voluntary sector (CVS) with improved links and care pathways between statutory and CVS services. Secular BME women-only CVS services with a track record of dealing with these issues and based on human rights principles should be fully funded and supported to develop such Projects. This should be reflected in commissioning criteria.

3. Services should provide early intervention and undertake preventative work as well as deal with crisis and acute care, and provide medium to long-term services, including specialist provision within the NHS, such as FGM Clinics.

4. There should also be a fully funded 24-hour freephone national helpline offering signposting, advice and initial counselling.

5. Minimum standards and guidance should be developed in consultation with the secular BME women's voluntary sector with a track record of providing services based on human rights principles. Bad practice such as racial and sexual discrimination and stereotyping, and practices which endanger lives such as non-intervention, mediation and reconciliation in the name of cultural or religious sensitivity, and deny health care for those with immigration problems should be eliminated. It should also introduce improved procedures to deal with confidentiality, security (including risk assessment), record keeping and the use of interpreters. These standards should be reflected in commissioning criteria.

6. Mandatory training on the needs of BME women should be introduced in professional occupational qualifications

and continuous professional development. The training should contain information on standards, guidance and procedures. The training module should be developed and delivered in conjunction with the secular BME women's voluntary sector.

7. The definition of 'culturally capable' services as promoted by Delivering Race Equality in mental health care should include services which target the needs of BME women experiencing domestic violence, which are 'women-centred' and which provide for their linguistic and cultural needs but which do not reinforce oppressive values and practices. 'Culturally competent' staff should also be required to address issues of gender as well as race inequality, and have an understanding of domestic violence and its impact on BME women. Faith-based or socially conservative organisations or intiatives should be avoided to prevent inequality of access to services and pressures on women to stay in or return to abusive situations.

8. Routine screening on domestic violence should be extended to all health services, including GPs and accident and emergency, and should incorporate issues affecting BME women, including questions to elicit information on domestic and sexual violence, harmful traditional practices and levels of depression, suicide ideation and self-harm, which may help with early intervention and prevention.

THERAPY

9. Medical practitioners should refer to and work in partnership with secular BME women's domestic violence advice, advocacy, counselling, refuge, support and befriending services. Inappropriate 'medicalisation' of BME women subjected to domestic violence should be avoided.

10. The new hybrid therapy model as developed by Shahrukh Husain should be adopted by mental health and counselling services as effective therapeutic intervention, particularly in the treatment of Post Traumatic Stress Disorder (PTSD) and other related conditions, such as Acute Stress Disorder, amongst South Asian and other BME women from similar social and cultural backgrounds subjected to domestic violence.

11. Domestic violence (incorporating harmful traditional practices) as experienced by BME women should be added to the DSM-IV-TR diagnostic criteria for PTSD, either as a sub-group within the Battered Women's Syndrome (as developed by the Survivor Theory) or in a category of its own, so that the impact of religious and cultural pressures such as notions of 'shame' and 'honour,' and of racism is taken into account. These values and experiences engender feelings of fear, shame and guilt which elevate the risk of developing PTSD.

12. The hybrid model should be promoted by the Department of Health, including through the Improving Access to Psychological Therapies Programme and other mainstream therapeutic initiatives.

13. Official medical guidance on mental health issues, such as the NICE guidance on self-harm and on PTSD and the Royal College of Psychiatry's guidance on domestic violence, should specifically incorporate guidance on the treatment of and support for BME women experiencing domestic violence.

14. Free local counselling and talking therapies targeting the needs of BME women, on a long-term basis ranging from 12 to 26 weeks, or longer if required, should be more readily available in mainstream and CVS services.

15. There should be more specialist counsellors and therapists reflecting the race, gender and linguistic background of the patient, with an understanding of the impact of racism and religious, cultural and social pressures on the mental health of abused BME women. Therapies which encourage the use of religious leaders and faith healers should be avoided as these can add to pressures on BME women to stay within or return to an abusive situation, and prevent their recovery from mental illness.

GOVERNMENT

16. The DH should establish a cross-government Ministerial Working Group or taskforce which includes specialist, secular BME women's CVS groups in order to tackle domestic violence and mental health problems amongst BME women.

17. One of the first tasks of the Working Group should be to hold a public inquiry into suicide and self-harm amongst abused BME women. This includes taking measures to address the disproportionate rate of suicide and self-harm amongst South Asian women and undertaking further research on prevalence and ways of tackling the problem amongst other BME women.

18. The Government's strategy on BME women, domestic violence and mental health must be integrated into the Government's strategy on domestic and sexual violence, and incorporated into the wider national strategy on violence against women and girls.

19. The Government's Women's Mental Health Strategy and Delivering Race Equality in mental health care action plan must include more targeted work on BME women, including establishment of small-scale and well-funded specialist hospitals and secure/ medium-secure units, women's day and resource centres, supported housing and refuges, including those which target the needs of young women/girls, and single-sex wards. In particular, BME women-only CVS services should be fully supported.

20. The Department of Health Victims of Violence and Abuse Prevention Programme (VVAPP) should also be fully implemented with initiatives targeting BME women.

21. There should be more targeted work on suicide and self-harm amongst BME women, which should be prioritised into goal 1 of the National Suicide Prevention Strategy.

22. National indicators on mental health and violence against women should be developed to include the need to provide specialist services, and policies and procedures to meet the needs of BME women.

23. The Quality Care Commission or other relevant Inspectorates should regularly monitor and enforce the implementation of policies and best practices in the health and social care services.

24. Designated staff responsible for domestic violence or violence against women within local health authorities should have an understanding of BME women's issues and work closely with trusted, local, secular BME women's organisations when developing services, policies, procedures and training programmes.

25. The Government's strategy on BME women, domestic violence and mental health must be mainstreamed into other social policies aimed at addressing related issues such as health, crime and child protection as well as in strategies to meet the requirements of the gender and the race equality duties, and anti-discrimination and human rights legislation and policy, such as those under the 1979 Convention for the Elimination of all Forms of Discrimination against Women (CEDAW).

LAW AND POLICY

26. The coroners' courts should use their powers to ensure that the causal or contributory link between domestic violence and suicide is fully examined and recognised in narrative verdicts, and that recommendations are made to public bodies to prevent future fatalities.

27. The Government should introduce a legal duty on public bodies to respond to coroners' recommendations within set time limits.

28. Specialist BME women's organisations and individuals with a track record of assisting BME women escaping domestic violence should be recognised as experts, and their expertise more readily used, by the coroners' courts on the social, religious and cultural pressures faced by BME women.

29. Specialist BME women's groups should be able to make third party interventions and be recognised as 'interested persons' in coroners' courts to raise issues of domestic violence in the public interest.

30. Coroners should receive guidance and training on BME women, domestic violence and suicide issues, provided in conjunction with specialist BME women's organisations.

31. Public funding should be available for inquest hearings.

32. A centralised system should be developed to monitor suicide/suspicious

deaths linked to domestic violence with an ethnic and gender breakdown.

33. Homicide reviews should not replace inquests in suicide cases, and should routinely examine the impact of any cultural, religious or racial issues on deaths, including suicide. They should have more independent scrutiny with effective implementation of recommendations and sharing of 'lessons learnt.'

34. Serious case reviews in child deaths should routinely examine how the issue of domestic violence, and any particular cultural, religious or racial issues, impacted on the death with a view to 'learning the lessons' and recommending reforms in policy and practice.

35. The Government should enact a new offence of homicide to improve the prosecution of criminal liability for suicide as recommended by SBS to the Law Commission. The proposed new offence of homicide 'Constructive manslaughter/ suicide aggravated by harassment or violence' should be defined as follows: 'Where a course of harassment or violence causes a person serious physical, psychiatric or psychological harm that directly results in a suicide or is a significant contributory factor in the suicide, the offender shall be guilty of constructive manslaughter/causing suicide aggravated by harassment or violence.'

36. At the scene of an unnatural death or suicide, the police should carry out a thorough investigation and treat the case as a potential 'crime' in case evidence comes to light in the future that casts doubt on the cause of death.

37. The Government's policy on women, immigration, asylum and 'no recourse to public funds' needs to be reformed in order to prevent deportation, detention and destitution, and thus reduce mental breakdown, suicide and self-harm amongst abused BME migrant women. In particular, all victims of gender-based violence should be covered by the domestic violence rule in immigration law, and an exemption to the no recourse to public funds requirement be introduced. There should also be mandatory adherence to gender asylum guidelines which advise Home Office officials to have a sympathetic approach and to recognise women's experience of abuse. Free access to healthcare should be available regardless of immigration status.

AWARENESS RAISING AND RESEARCH

39. There should be more research into the links between domestic violence and mental health amongst BME women, but avoid having 'too many reports and not enough action.'

40. There should be better monitoring and data collection within the NHS and other public bodies relevant to BME women, domestic violence and mental health.

41. There should be a national well-funded public awareness raising campaign to inform BME women of their rights and

how to escape domestic violence and overcome mental health problems, and to change social attitudes on mental health and violence against women and girls within BME communities.

42. The national curriculum should include the teaching of issues such as domestic violence, mental health, suicide and self-harm to children and young people together with initiatives to provide counselling and support to young BME women/girls in schools/colleges with a large BME populations.

43. Community based work within BME communities should be developed in schools, colleges and youth centres, and amongst women and men within BME communities more generally. This work should be led by or in consultation with secular BME women's groups with an expertise on addressing these issues, and not simply delegated to community leaders or faith-based groups who have a history of supporting conservative views on gender roles and abuse within the family.

Appendix 1

RESEARCH

As part of the Domestic Violence and Mental Health Project, SBS surveyed agencies, undertaking mental health work, on their experience of and views on BME women, domestic violence and mental health in order to assess practice and make recommendations.

Women from various BME communities have similar experiences of domestic violence and mental health problems, which include religious and cultural pressures, immigration and asylum issues, suicide and self-harm, racism and discrimination, low socio-economic status or financial hardship, and a health service which medicalises them or ignores their needs rather than provide counselling or social welfare support. However, in some respects their experiences differ: for example, African Caribbean women report a greater sense of blatant racism from the health service and other agencies, such as the police and social services.

The research sample

In the period July 2004 to April 2005, SBS conducted interviews with 36 agencies. The profile of agencies is as follows:

- 31 voluntary sector agencies (including survivor groups)
- 5 statutory agencies

*7 of the above organisations have a national remit;

*2 of the national agencies were direct service providers;

*3 were national mental health organisations with a policy remit;

*2 were national BME mental health organisations with a remit of policy development.

The agencies were located in the following areas:

Location	Number of agencies
London	18
Manchester	3
Edinburgh	2
Gloucester	1
Birmingham	1
Leicester	1
West Sussex	1
Bristol	2
Bradford	1
Wolverhampton	2
Liverpool	1
Cambridge	1
Sheffield	1
West Bromwich	1

While there are 18 organisations based in London, there is an equal number located in other parts of the UK. London has a larger number of organisations specialising in BME issues, which is reflective of its ethnically diverse population. London is also the headquarters for organisations with a wider national remit.

An overview of the client group of each agency:

- Generic services, which included BME women
- Women only services which included BME women
- BME women only services.

The BME populations represented include:

- South Asian
- African
- Caribbean
- Chinese
- Vietnamese
- Middle Eastern
- Jewish

The type of services represented in the sample include:

- Information, sign-posting/referral, advice and advocacy on mental health and/or welfare and social care issues
- Telephone help-lines
- Day centres and resource centres, including crisis centres for the mentally ill
- Residential accommodation and support
- Assessment and community care services
- Counselling, psychotherapy and psychiatric services
- Complementary therapies and creative activities
- Befriending, mentoring and accompanying services
- Support, recovery and self-help group therapy and activities
- Social support for carers and family liaison
- Floating support and outreach, including in homes, hospitals/clinics, GP surgeries, and secure units and prisons.
- Holistic services including complex issues such as alcohol and substance misuse, disabilities, transcultural issues and violence and abuse.
- Employment and education support
- Health promotion within communities
- Developmental, training, consultancy, conferences and networking
- Research, campaigning and policy
- Generic and/or specialist provision for BME women or BME communities

Research findings

The survey findings highlighted the complexity of issues which affect BME women's experience of mental distress.

Overwhelmingly, the findings reflected the underlying, multiple discriminations faced by BME women. Intersecting gender, race and other inequalities clearly multiply the levels at which black women experience social exclusion, giving rise to a plethora of issues. For example, one agency said:

> *' …once there is a mental health diagnosis, then it leaves women unfit for many roles in society, i.e. as a mother. If you are a woman in the mental health service it's bad, if you are a lesbian woman in the service then it's worse, if you are a black lesbian in the service, then forget all positive chances within mental health service provision.'*

While there were specific and unique experiences for particular ethnic minority groups, the survey confirmed the view that there are many experiences shared in common by BME women with mental health issues in Britain. These are clearly rooted within gender inequalities, poverty and racist practices, both within society and the institutions with which they come into contact in the mental health system.

NATURE OF MENTAL ILLNESS

In the survey, eight agencies found that depression was a key symptom of the distress experienced. Many agencies spoke of the spectrum of symptoms which included:

> *'Self-harm, suicide, classic post traumatic stress disorder, not sleeping, inability to trust, self-blame, crying, depression, flashbacks'*

> *'There are a range of presenting issues. Many have schizophrenia, bi-polar depression, psychosis, neurosis, eating disorders.'*

Sixteen agencies reported the prevalence of self-harm and suicide amongst BME women. One agency said that the rate of self-harm was as follows: *'self-harm 25%; suicide contemplated "I can't go on" 20%; suicide attempted 10%'.* One agency talked about how the high rate of suicide amongst women in Hong Kong is mirrored in UK. Another said that: *'self-harm is often seen by the community as a European 'issue' but we are now seeing more and more clients burning, cutting, bleaching their face, painting face white (sic) to be acceptable by the predominant race.'*

Contributory, causative and compounding factors

The following were the key issues highlighted in the interviews:

i.Gender violence/domestic violence (22 agencies)

Gender violence and abuse was clearly one of the key issues contributing to the mental distress experienced by BME women. Although many agencies did not monitor or keep statistics on the level of gender violence, professionals noted that it was experienced by many BME women. Some stated that the history of violence was not discovered during the assessment process but uncovered later within the therapeutic relationship. However, mental health and gender-based violence were often treated separately, and within mental health services, if women were experiencing multiple issues, then gender violence would be the last issue to be dealt with.

Domestic violence was the main form of gender violence that women experienced, either from childhood, past relationships or within current relationships. Eight agencies reported that this is compounded by gender inequality and race discrimination.

It was also clear that, for many women, the shame associated with abuse, is often reinforced by conservative religious and cultural values such as 'honour' (12 agencies), which makes disclosure difficult and prevents women from leaving abusive situations. One agency said that:

> *'One client in the domestic violence group disclosed that the only way she could cope with the beatings is that she was told by her imam that the parts of her body hit by her husband will not burn in hell. There are many other similar stories where they are told it is part of their religion and to put up with it'*

The agency also talked about the impact of extreme forms of gender violence

such as FGM on sexual health and mental distress:

'there are repeated difficulties women then have around periods, kidneys, infection, child labour, normal sexual relationships. Knowing where to go to get it reversed and the cultural difficulties that come with it cause mental distress'.

Other forms of gender violence included rape and sexual harassment outside of the family, and trafficking and abuse experienced in prostitution (six agencies). Other agencies said that mental health was

'related to the violence they have experienced. Sixty eight per cent had experienced violence prior to trafficking. All have been raped.'

The experience of rape in war and conflict also impact on some women, especially asylum seekers:

'*All of the women have a history of violence. Rape has been used as a tool of war, either they have seen it happen to others or have been raped themselves. Fathers rape their own daughters at gun point. We have had a client raped at gun point.'*

The failure to protect women from gender violence added to women's mental distress. One agency said:

' women with mental heath difficulties were less likely to be believed. So if a woman with mental health problems called the police for protection against gender violence, her story was likely to be doubted'.

Alarmingly, two agencies spoke about black women they knew who had experienced further abuse while in the psychiatric system.

'Black women experience physical and mental abuse when in the mental health system. We know of cases where women have been raped and assaulted within the system'.

ii. Immigration

Immigration problems were considered by 21 agencies to be one of the key factors leading to the mental distress experienced by many of the BME women, often compounding the experience of domestic violence. Stories of fleeing war-torn countries often combined with the anxiety of leaving family and loved ones behind in the country of origin. For many, the racism, discrimination, loss of status, social isolation, poor housing, inability to have access to social welfare, working in low-paid jobs, having to negotiate living in an often hostile and different culture, the uncertainty of their future in relation to their immigration status, and the length of the immigration process decision making led to acute distress.

One agency working with Chinese women said that their clients ended up in the sex industry/massage parlours because of their illegal immigration status which prevented them working;

'Thing we are most worried about, because[their] status is illegal/claiming asylum, are the periodic clampdowns by authorities. It means that (Chinese women) have no other economic means, which can make them vulnerable to working within sex industry/massage parlours. As they are in debt without a source of income…lack of work permits

lead to a black economy. Women are therefore unable to access services because they are illegal.'

They also got into debt with criminal gangs which triggered mental health problems. One counsellor stated that often what drove women over the edge was the treatment within the system, that their stories were not believed despite the fact that they had survived traumatic experiences in their countries of origin. Agencies said the following:

'Many women are fleeing war-torn countries. Arriving here they have to deal with a multitude of issues which compromises their mental health. Many of the women will have experienced violence and sexual trauma. They would not have had a chance to process this and coming here and facing issues can send them over the edge. Almost 90 per cent of the women speak about not being able to deal with the fact that many don't believe their stories, particularly courts/immigration officials. This can be even more damaging to their mental heath than the actual physical violence they have suffered and can therefore take even longer for the healing/recovery process.'

' There is an immigration camp outside of Cambridge which has led to real bigotry. For us we have seen a big impact/effect of the changes in the Supporting People funding. We are unable to house those with no recourse to public funds. Previously we were able to be much more flexible around women whose status was unsure. This has particularly affected women. Women will do anything to stay off the streets, which leaves them vulnerable to exploitation.

'Problems around immigration, many Jamaicans overstay and then are vulnerable to 'men' manipulating them and their position. Normally,[with] overstayers who marry, he is alright and then after a few months he becomes abusive and she has no rights, due to her immigration status, and is open to exploitation.'

iii. Racism

According to 19 agencies, the impact of racism, the consequent discrimination and the lack of opportunities in accessing education and training, on BME women's mental health was deemed to be a critical issue. One agency said that,

'*Race and discrimination are additional pressures for BME women. Some will be more adversely affected than others, particularly in the work place, some feel over- monitored.'* Another found that, *'Racism, housing, poverty are all key issues; these are the main focus for the team. Often clients don't complain about racism, until they have a psychotic breakdown and it becomes part of the episode'.*

Yet another agency stated that:

'Migrant (Chinese) communities who arrived in the 50s, 60s sacrificed much to watch their children succeed. They are statistically a very successful

community. It is after they complete graduation, that is when they face institutional racism. They struggle to get into narrow fields.... So they then re-enter the Chinese community, into catering/supermarket[jobs] and ancillary services. It is then in their late 20s, 30s we see many clients who are disappointed /disillusioned with reality. There is family pressure to succeed, to get a wife/husband. Now there are more arranged marriages between mainland China/Hong Kong. It makes them very vulnerable to depression. There is a disproportionately higher figure of suicides, largely if you are in a very achievement orientated type of environment, and then it is difficult to cope with failure'

Two agencies highlighted the legacy of slavery and the holocaust on mental health. One agency said:

'*Mental health is related to issues around the legacy of slavery: concepts of beauty and being virtuous and how they view and value themselves – 100 years later the impact is still there, it is deep rooted in the psyche.'*

iv. Alcohol/substance misuse – dual diagnosis

Substance misuse, either by the individual woman herself or the impact of misuse by another family member, was highlighted as a source of distress by 18 agencies. One agency found that they *'have seen clients with drug psychosis and it's becoming more of an issue.'* Within the wider family, the issue of gang culture and drugs was also a pressure point. According to one agency:

'Gun/gang culture and drug culture affects women whose children are part of gangs and guns; it triggers mental health difficulties….we are working with a mother and daughter, and the daughter is involved with a man who is involved in gun/gang culture. Women are viewed as safe houses(sic) to hold guns/drugs, but if found out then she is implicated and goes down'

The links between cannabis and crack/cocaine psychosis and prostitution were also highlighted.

v. Low socio-economic status or factors

Sixteen agencies reported that women were unable to leave a violent relationship because of the socio-economic factors, such as fear or experience of poverty and homelessness. One agency said:

'We had a conference which explored domestic violence. It is a very predominant issue through the women's group. The conference provoked a lot of controversy and defensiveness…It is a very taboo subject, specifically for women. If the male is the breadwinner, for socio-economic reasons, it means they stay in the relationships.'

Where women are employed in the family business, it becomes even more difficult for them to leave an abusive relationship:

'Because the majority of the Cantonese community are in the catering trade it therefore means they have worked in the family business. It means that the experience of women is that they

have had no opportunity to move and mix beyond the immediate family and Chinese community. They work very long hours and only speak Cantonese. What this means is that if they suffer mental ill health or violence they put up with it for many years until [the] children leave home…when the immediate needs of financing the family begin to recede, the breakdown of relationships become more prominent and overwhelming. Many of the issues would have been there for many years, but it is as the children leave that the fallout takes place.'

The low socio-economic status of BME women, as a result of poverty, debt, poor housing, unemployment, and problems with access to benefits, particularly no recourse to public funds, was itself a key contributing factor to their mental distress.

'Many Iraqi women are depressed, don't speak English, don't work as it's difficult to get a reference… Some of them were working in Iraq as doctors and accountants and now they can't even get the most simplest of jobs.' One agency fount that, *'Many women try very hard to provide all they can for the children, even if it means going into debt, which spirals into more debt. We spend a lot of our time working to prevent clients going to court.'*

Linked to this was the lack of opportunities and prospects, not only as BME women, but also with a diagnosis of mental health problems. *'Once you have had a mental health difficulty, in the job sector, that's it, you're finished with that label.'* Another agency told us that,*'70 – 75% of [the] orthodox Jewish community is on benefits contrary to the popular stereotype'.*

vi. Social isolation

Twelve agencies reported that women experienced social isolation due to a range of reasons, such as leaving a violent relationship and lack of social/ family support networks. One agency found that Chinese women, *'are socially and geographically isolated and have no English. This exacerbates their situation and brings it to a crisis. They are desolate with very low esteem. Very lonely and lost. As a result, they become very desperate.'*

vii. Childcare/child protection

The pressures of childcare were considered a key issue by ten agencies. However, for women already within the mental health system, childcare, expulsion from school and, more specifically, the fear of having their children taken away from them was a major source of distress. Furthermore, the general pressures of mothering in a society that did not value or support this role was apparent; for single mothers the pressures were even greater. One agency worker said:

'We work with single homeless, with women who will have had children removed or have had to enter into an informal arrangement of care, which is often unsatisfactory in relation to their access.'

For one agency, a suicide case within the Vietnamese community exemplified the grave implications for women whose

children were removed:

> *'Two years ago, a single mother with schizophrenia was admitted under section 3 into hospital for treatment. She had a very happy 18 month boy who had to be fostered. The treatment was going very well, except during one of the reviews, the family and children team social worker, suggested the idea that the boy be adopted into another family. We immediately challenged this…but the [client] took it very seriously, despite our reassurances that we would support her. She was getting better and would be given leave, and would then go to visit her son at the foster carers. One day she made Vietnamese food and took clothes for the son. After she left (the visit) she went to a high rise block and jumped.'*

Women often feel that their failure as mothers because of their mental health difficulties contributes to their children's failure to thrive as adults which then act as yet another pressure point on their already fragile state of mind.

> *'We have clients who have children who went on to have many difficulties in later life (drugs etc). [The]mother then goes on to feel that she is a failure. She told her co-ordinator that she was a failure and wanted to commit suicide; she then got sectioned'*

viii. Difficult family relationships and inter-generational conflict

Nine agencies cited difficult family relationships and eight agencies mentioned inter-generational conflicts contributing to mental health problems, and the experience of abuse.

> *'Children are growing up learning English as a first language instead of Vietnamese and therefore the impact on the family means that very few can communicate with their parents.'*

Women are the main carers in the family, not only in relation to children, but also other dependents in the extended family. This is both a cause of and additional stress on women experiencing mental health problems.

ix. Low self-esteem and self-confidence

Seven agencies felt that low self-esteem can lead some BME women into vulnerable and abusive relationships,

> *'women with very low self-esteem think that because they have mental health difficulties that no one will have them and so will sleep 'with anyone' and have unprotected sex which makes them further vulnerable.'*

Sometimes low self-esteem is connected with experience of racism which compounds experience of gender violence:

> *'Bleaching of pigmentation is a big issue. Women are doing all sorts to be accepted, society doesn't reflect the beauty of black people. Many clients look in the mirror and only see negativity and self-hatred. The saddest thing is when they can't accept themselves'*

x. Other

Other factors mentioned in a few interviews were work related stress and unresolved grief or bereavement.

THE FAMILY AND COMMUNITY RESPONSE

Agencies reported that BME women with mental health problems are often stigmatised and emotionally abused by the family and community. Some are deserted and ignored, while others are referred to medical help or to alternatives sources of help such as priests or herbalists. As a result, women become isolated and are vulnerable to spiralling depression.

Agencies working with African-Caribbean women said:

> *'Many families take women straight to psychiatrists, often in a crisis situation where the woman's mental health has deteriorated, and insist on her being sectioned. Then family members are shocked at the lack of support and safety in hospitals, particularly for the young and those in their first episode. It is a very frightening experience for them. Older people are sick in the streets and taken to hospital by the police…Every family would have gone to priests of some kind. Priests would splash water, or in more extreme situations, use witchcraft. The family is under pressure to do something once people in the community know about the illness'*

It is impossible to know the true number of women who are locked away by their families, while others use 'alternative' cures:

> *'There is a hidden statistic where families have looked after their children for many years without coming out of the house, won't know any services except for the GP, but family will liaise and get medication for family member…some clients do not want to have contact with family… they are already displaced and so even further isolated'.*

The stigma attached to mental illness can invisibilise the extent of the problem:

> *'The community treats mental illness as a weakness/devilish. They do not ostracise families, but families leave women to get better - woman becomes invisible, the walking dead. In cases of violence and mental health, extended family/neighbours do not hear the cry for help and do not know what to do. What happens behind closed doors, stays there. They have old fashioned attitudes.'*

An agency working with the African community found that:

> *'The black community is so secretive – one portion will go to the church, others will go to the Ju Ju/Obiah, others will go to the mainstream community, some will go to alternative therapies, but it is a very new concept and rare. The community is afraid – has not embraced the issue…there is a big stigma of mental health – difficult to know how to change this when the media still continues to feed stereotypes.'*

Interestingly, Chinese and Vietnamese women are taken by their families to see Western doctors despite their reliance on traditional Chinese medicine for other ailments. Seeking help from outside the community may be an attempt to maintain privacy:

> *'Families do not generally support the mentally ill. Mental illness is a social stigma, and regarded as an external*

evil spirit. Some go to the temple for blessings from ancestors – they spend a lot of money on temples. If [the]problem is not resolved, they go to[the] herbalist/ GP and are referred to psychiatrists and social workers. Family will not reject a member, but will go into denial. There is a strong belief that 'craziness' is deviant behaviour. Only when families experience mental health through a family member, they may begin to understand the problem, and seek help from western medicine.'

Cultural norms in East Asian communities where women are not expected to express their emotions but devote themselves to their families with a stoic spirit can further exacerbate mental health issues. South Asian communities have a tendency to go into denial and to resolve issues through internal community mechanisms:

'There is denial particularly of post-natal depression. Many are isolated by families, but some families do make referrals. If they experience a miscarriage, some clients believe they have been 'cursed' and have 'evil spirits'. Sometimes families go to a spiritual healer, who is often not friendly. GP is not the first port of call – women would go to a female family member they trust first, and then may be referred to GP or another agency, such as health visitor or social worker.'

As discussed in earlier chapters, there are many issues, mainly to do with control of women's sexuality and behaviour, that bring dishonour to a family.

'Izzat (honour) and sharam (shame), pressures of not giving birth to boys, loss of role, social isolation; being married to someone with multiple wives; loss of role for older Asian women, are all issues for Asian women.'

Issues for younger women are different from those facing older Asian women:

'For older Asian women referrals are very different. Women aged 40 plus have had a family and have now become clinically depressed, become immobilised. Often issues are around loss of identity and family, the role change from mothers.'

Younger Asian women may have to cope with transnational marriages:

'For young Asian women, there is family pressure to achieve, to have arranged or forced marriages. If the partner comes from abroad, young Asian women may find themselves as the main breadwinner. Women have the stress of undercover relationships where family do not (sic) approve and the pressures of transition from secondary to higher education. There are often conflicting expectations'.

THE AGENCY (OR STATUTORY) RESPONSE

Lack of early intervention, leading to crisis

It was evident that the lack of early intervention contributed to later crisis. Agencies commented:

'Both men and women have been left in the community festering, they have

had crises in the past, have had a service from the statutory services, have not been happy with the intervention, or it's not been the right type of intervention and have therefore not engaged with services. Clients have then gone on to have continued crises/depression with no intervention until they reach crisis point again. Often what was a case of depression, which is not picked up, goes on to become a psychosis and so once they show up at the psychiatrist's, they will be treated for the psychosis and the underlying issue of depression is never treated'

Agencies which are more aware of mental health issues were more likely to identify a problem early, particularly if the patient is self-harming. Others, however, may fail to pick up the problem at an early stage. *'Social workers, health visitors and others have a vital role in dealing with mental illness'.*

Services misunderstanding needs of women and discrimination

These included misdiagnosis of BME women's distress resulting from racist stereotyping and discrimination. One worker said:

'My experience is that Black, African and African-Caribbean women particularly have to deal with very rigid stereotypes: patois, yardies, lots of children, druggies. Often clients feel they have to live up to that self-fulfilling prophecy.'

Agencies also highlighted the over-representation of African and African Caribbean women in acute in-patient care:

'There are discrimination issues in the way that they are treated when they are using psychiatric services. Often when using services they are made to feel problematised, (given) inappropriate diagnosis. There are high doses of anti-psychotic medication, poor care planning, lack of referrals to alternative treatments and lack of referrals to services in general.'

Lack of appropriate services

One agency stated that the lack of women only spaces within hospitals was an issue in providing appropriate services. Lack of community language interpreters acted as a barrier to access appropriate interventions. Lack of women medical staff was another issue:

'One Asian girl who comes here, refused a depot injection, which is only meant to be administered in your bottom. She said she hadn't understood why she needed to be stripped naked for this injection to be administered and why there was no female staff…'

Appropriate services may also not be used properly by other agencies. One agency said:

'Agencies did not make appropriate referrals as they were unaware of specialist services, such as Chinese organisations. Mainstream agencies only contact them for interpretation services. Our services are not recognised by health professionals – we need recognition and respect, not dumping.'

Agencies said that if voluntary sector agencies get involved, they may be able to

intervene in good time:

'We have one client who had a visit from a social worker. Based on her visit she felt that the mother talked 'bizarre' and recommended that the children be taken into care. We intervened and advocated on the client and children's behalf by getting social services to look at the fact that children were well looked after/ good at school, and had (good) support mechanisms. We were successful in not having [the]children taken away.'

Medication

Medication appears to be the primary form of treatment for BME women:

'Most of the services black women receive are medical – it is only when they access a voluntary sector organisation that they will have access to counselling and alternative therapies…there are still not many black women accessing counselling services – this is due to lack of knowledge and access'.

Over-medicalisation was highlighted, as were the side effects, and the need for women to comply with the medication and treatment as well as the lack of information provided in understanding the medication administered. Agencies reported the following:

'A key issue is the impact of medication and its side effects: weight and other physical symptoms, especially amongst younger women, further spirals into depression and self-neglect. 'What's the point, nothing fits, don't look good.''

RECOMMENDATIONS

The agencies, which were surveyed, made the following recommendations:

- There should be a more holistic model of care which provides counselling and help with social and welfare problems.

  'if what we are presented with is chaos i.e. social problems causing psychological distress, the solution is to pragmatically deal with untangling all the issues leading to the psychological distress'.

- More funding for survivors and voluntary sector groups – should not have to rely on local authorities or health authorities. There should be more central government funding.
- There should be more specialist counsellors of the same ethnicity and gender as the patient with a better understanding of cultural and religious issues within BME communities and the impact of these and gender inequalities on women.
- Practices which over-medicate BME women should be avoided and alternative therapies, such as psychotherapy, should be more accessible.

  'A good model is one which does not medicate immediately – is willing to listen, give choices of care and treatment. Medication should be the last resort'.

- There should be a national help-line for psychotherapy and counselling for BME women.
- Health services must maintain confidentiality to ensure people use services
- More training for professionals to improve their understanding and practice

in relation to BME women with health problems, including looking at equality and diversity issues.

- Mainstream service providers should meet the mental health needs of BME communities – this should be a more reflective practice consulting with BME women's groups, and not community leaders, and working in partnership with voluntary and community groups. There should be, *'more equitable access to mainstream services which are culturally competent'.*
- There should be more guidance for agencies on how to provide effective services – more information on practice than theory.
- Government should not deport people with mental health problems – it owes a duty of care to these people.
- Health services should challenge the stigma of mental health.
- There should be more welfare benefits and housing rights for those with immigration problems.
- There needs to be more supported housing for the mentally ill.
- There should be more advocacy and support services for those who experience abuse and mental health problems.
- There should be more research into the link between domestic violence and mental health in BME communities, but avoid having *'too many reports and not enough action'.*

Appendix 2

CONSULTATION: CONFERENCES & SEMINARS

The Domestic Violence and Mental Health Project intervened in a number of events and working groups on mental health issues in order to influence policy and practice, research data and to consult others working in the field. For example, it regularly attended the expert panel on domestic violence organised by the DH Victims of Violence and Abuse Prevention Programme, responded to their Delphi consultation questionnaire and organised a focus group for the victim's pathways project.

Over the years, SBS has contributed to conferences and seminars and, in some cases, also made keynote presentations, including to the DH's Delivering Race Equality: A Framework for Action in mental health care conference (2005) and the Royal College of Nursing conference on the needs of BME women in the health service (2009). We have also attended voluntary and community sector events organised by Zindaagi in East London, Karma Nirvana in Derby and by the Greater London Domestic Violence Project. SBS also attended and contributed to local events for the Southall and Ealing area organised by the Ealing Primary Care Trust on suicide and self-harm, and attended Ealing Suicide Prevention Steering Group meetings.

Additionally, SBS raised mental health issues in domestic violence events and consultations, such as the Home Office *Safety and Justice* consultation exercise before the drafting of the Domestic Violence, Victims and Crime Bill 2004, at the United Nations hearings on the UK report to the Convention for the Elimination of all forms of Discrimination against Women (CEDAW) Committee in 2008 (see 'Introduction' for CEDAW committee conclusions on issues raised by SBS), and the 2009 consultation by the Home Office on its *Together we can End Violence against Women and Girls Strategy.* Also, in 2009, we participated in the DH's Taskforce on the Health Aspects of Violence Against Women and Children, which included making a contribution to the harmful cultural practices sub-group and organising a focus group of survivors at SBS.

SBS also organised the following two events aimed at sharing information and consulting practitioners and policy makers on specific issues in relation to BME women.

Seminar on 'Black/Minority Women, Domestic Violence and Mental Health'

SBS held this seminar in April 2003 attended by 20 participants including representatives from the Department of Health, National Institute of Mental Health in England, Women's Therapy Centre, Zindaagi/ Newham Asian Women's Project, Nafsiyat, Akina Mama Wa Afrika, Women's Aid, Inquest and Home Office Coroner Reform Team. It also attracted some individuals such as psychiatrists, psychologists and researchers.

Key issues

SBS raised the following issues at the seminar:

- Women have a range of experiences of mental ill health resulting from mild

depression to psychiatric disorders and include self-harm and suicide

- Research shows Asian women are 2-3 times more likely commit suicide than women in the general population. They are also more likely to consider or attempt suicide. Rates are high for young Asian women, particularly those aged 15-34.
- SBS experience shows that causal factors are primarily environmental for many Asian women although psychiatric illness can also exist in some cases. Suicide research shows Asian women do not usually have a psychiatric history.
- Causal factors for Asian women are domestic violence and oppressive cultural practices, such as forced marriage
- Women's experiences are compounded by other factors, such as racism, immigration problems, imprisonment/ detention etc.
- Obstacles to escaping domestic violence e.g. cultural notions of shame and honour, racial discrimination.
- Inappropriate or non-intervention by service agencies
- The role of coroners' courts in monitoring trends and directing public services

Questions

SBS asked the seminar to consider the following questions:

1. How should the health service respond to the problem?
2. How should other service agencies respond?
3. How can the coroners' rules and procedures be reformed?
4. What can the Government do?
5. Is other action required, e.g. in the community, with or for women?
6. How can specialist services be developed?
7. What is a good model of intervention?

Presentations

Presentations and discussion at the seminar highlighted the following issues:

- Disproportionately high rate of suicide and self-harm amongst Asian women is linked to domestic violence and oppressive practices.*'Suicide is the tip of the iceberg – for every woman that succeeds in killing herself, there are many more in need of help.'*
- The last 30 years have not seen much change in the treatment of Asian women – their problems are still being medicalised and individualised rather than put in a wider social context. Addressing social and psychological issues should be part of the package of issues which need to be addressed – the internal and external world.
- Many women kill themselves in prison and a disproportionate number are black women. There are not a large number of Asian women in secure facilities, maybe because they are killing themselves before they reach this stage, apart from those in specific secure units like in North West London. There are a significant number of African and Caribbean women in maximum security – 16 per cent of the population.

  'I am horrified by the number of African women sectioned…women are being sectioned for instance when a woman is overwrought with anxiety and

depression and she runs out in the street – or where women are just praying or shouting'.

- Inquests are an important mechanism for the community to question cause of death, and given what we know about the death of Asian women, it is crucial that somebody is representing their interests.
- Many refuges will not house women with mental health problems because of their specialist and high support needs. There is also a lack of outreach services and specialist counselling and support, particularly for black women.
- At a national level there is a lack of recognition of causal factors such as domestic violence which is linked to oppression, and immigration problems – there needs to be more performance indicators and directives by the DH to address the problem of domestic violence and mental health, particularly in mental health settings.
- Many mental health services are 'gender blind' and 'culturally blind'. There are no services for black women and there is a reluctance on the part of the Royal College of Psychiatry to provide a culturally sensitive service.
- There is also a lot of pressure on mental health services and it is difficult to sustain partnerships between the voluntary and community sector (VCS) and the NHS. The VCS is 'dumped upon' and 'used and abused' because it lacks resources and is not listened to. Non-statutory counselling and therapy services do not have enough money to meet the demand and there are not enough trained psychotherapists who can offer services. There is also a need for multilingual and multicultural services. Those which do currently exist are marginalised, and some interpreters reflect conservative views of the community.These services need to be properly funded and not just *'desperately trying to filling a gap'* as their services are preferred by survivors where they feel *'home from home'*:

  'Southall Black Sisters' in-house therapy work is just fantastic, and I am sure if you ask women where they would rather be, SBS, their doctor's surgery or a hospital, I can guess what they are going to say.'

- Money should follow the patient, but this is not happening – Family Practitioners Committees (FPCs) are only giving money to the statutory sector – this problem needs to be resolved. The National Service Framework recognises the need for statutory and voluntary sector services as the well as the need for them to work together.
- For many women, honour is a major issue in psychotherapy as it has been transmitted down generations and is entrenched. The community often denies the social causes of suicide which indicates complicity in the oppression of women. This complicity does not only include male members and elders of the community, but also women because they *'accept these traditional concepts and their experience of not being able to comply as something evil or bad within themselves'.* Many also have a fear of disclosing abuse because of the dishonour this brings, and because of the way the family and community responds:

  'A large proportion of young Asian women in Tower Hamlets are being put

into hospital by their families as a way of avoiding shame in the community. Because they are disclosing sexual abuse within the family, they are being pathologised'

- It is still taboo to talk about depression, mental health and other related matters, and therapeutic work is still rare – it is a luxury that most women could not afford because of the need to address practical issues. We need to develop our own understanding of therapy and its role in dealing with long term patterns of abuse.
- Important for GPs to become aware of and use psychotherapy more. There is no pressure from the minority community to do this as mental health is a taboo, and Primary Care Trusts (PCT) follow the prescribed models by the Royal College of Psychiatry. Use the work of progressive GPs as the best practice models to lobby the DH and FPCs for change.
- Need to *'catch the problem early so then it will not be so bad further down the line'*. There is a need for advice, counselling, support groups, education and work with male perpetrators of abuse to change their behaviour. Older women and siblings also need to be educated to stop them persecuting young women.
- Services need a service user perspective and standards. There is a lack of supported housing so local authorities end up putting BME women in racist areas or do not treat single women as vulnerable for housing purposes, particularly where mental health issues have not been clinically diagnosed.

'A young Caribbean girl from South London who...left home because of sexual abuse and physical abuse and a boyfriend who stalked her...She was an 18 year old girl who went to the local council and asked for somewhere to stay and they got her to sign a disclaimer to say that she did not want housing any more because this was not a good area for her to be in, so she went back to the place of abuse ...she started hitting the bottle..'

Seminar recommendations

The seminar concluded with the following recommendations:

- More funding from DH and other sources is needed for frontline domestic violence and mental health services for BME women – this should be a government priority
- A working group on BME women, domestic violence and mental health should be established by SBS involving BME women and survivor groups, voluntary and statutory mental health services, such as PCTs, and government representatives with the aim of lobbying for reform and documenting relevant issues
- There should be a range of supported accommodation with adequate resources with a crisis preventative approach
- There should be better funded refuge accommodation for BME women with mental health problems and hostel type supported housing for young women.
- The needs of women in prison and in hospitals should be more adequately addressed
- The coroners' courts should accept

third party interventions by BME women's groups to represent the interests of those who commit suicide

- Money should be made available to support 'what works' in consultation with BME women's groups
- There should be more trained psychotherapists knowledgeable about the BME women's needs in relation to domestic violence
- Childcare while women access counselling and other services should be available
- There should be more training for professionals on BME women, domestic violence and mental health issues
- There needs to be more awareness raising in the community about the benefits of psychotherapy and to challenge the stigma of mental health problems.

CONFERENCE WORKSHOP: 'OLD STORIES, NEW LIVES'

In November 2004, SBS hosted a conference entitled *Old Stories New Lives: Raising Standards to Tackle Violence Against Black and Minority Women.* The conference attracted over 300 people from the statutory and voluntary sectors. It held a workshop on health, mental health and gender based violence against BME women and included speakers from the DH, Home Office Coroners and Burials Team, Forward, Zindaagi (Newham Asian Women's Group) and SBS. In the briefing for the workshop, SBS summarised some of the main issues and asked the following questions:

- How is the Government's strategy on women's mental health and suicide working in your area?
- What resources and services are needed to improve counselling and psychotherapy and other specialist services (such as housing) for BME women with mental health problems?
- How can mental health provision be improved in prisons and detention centres? Should the DH establish an inter-disciplinary group, with representation from the BME women's voluntary sector, to tackle the high rate of suicide and self-harm amongst BME women?
- Should coroners' courts be required to investigate and pronounce verdicts which reflect gender violence as a contributory or causal factor in deaths and to hear expert evidence providing background information?
- Should coroners be required to make recommendations to public bodies for reform, and hold an inquest with a jury, where a death could have been prevented?
- Should women's groups have *locus standi* to make third party interventions in a range of legal cases, including inquests, on behalf of victims unable to act for themselves and in the public interest?
- Should full legal aid be available for representation and preparation of cases for inquest?

Topics of discussion

The discussion included the following issues:

- There is a need to record ethnicity on death certificates
- Routine screening of domestic violence in maternity units needs to be extended to Accident and Emergency wards,

as the DH intends to do

- Some groups are considering working with parents and community leaders to tackle domestic violence and mental health problems
- FGM causes long-term physical and psychological problems for girls and as adults

> *' …people are so scared to do the wrong thing [on FGM) because they will be called racist, that they end up doing the wrong thing. So it is the same thing as with a lot of domestic violence. The statutory sector will not respond because it is cultural, it is traditional, you can go home now, it was two days ago and it is okay. We have exactly the same thing with FGM, 'oh, it is culture, it is tradition, it is religion, I had better not say anything just in case everybody thinks that I am not PC'. But for me, as an activist, to fail to protect an African girl from female genital mutilation is racist. If it was a little white girl, nobody would think twice. The way I look at it is, if it is not good for your daughter, then it is not good for mine.'*

- GPs are not making referrals to counselling and use anti-depressants instead
- BME women are afraid that their family GP will breach confidentiality
- Need to address the mental health needs of asylum seekers who have escaped abuse and trauma abroad
- Performance indicators on domestic violence and mental health issues for BME women in health services will help with monitoring and implementation
- Specialist counselling is needed where there is a choice on the race, gender and age of counsellor who has an awareness of issues concerning abuse
- Counselling services should be provided with childcare and transport
- Should be able to access counselling through many routes – not just GP, and should be offered longer-term counselling.
- Need better counselling and advocacy services for women in prison, and alternatives to custody.

> *'The whole psychiatric service and the way they have developed is a bit like the issue around women in prison, in that we are talking about systems that have been designed primarily for men. I think what is actually needed is much more investment in looking at alternatives to those kind of traditional roots, where women who were deemed to be mad, bad and dangerous would just get locked up in places that really are going to exacerbate any kind of mental health problems they have. I do think that that is a reason why there are such high rates of suicide and self-harm… What we need is more investment, more research into alternatives from either custody, or if you are not detaining a woman under mental health, into other kind of alternatives that are looking into reasons behind women's mental health problems, which we all know are very often linked to other things. The problem is there is very little out there. I know of a very, very good project up in Scotland. It is acting as an alternative to custody. It is multi-agency, and it is absolutely phenomenal, the work that the women there are doing with some very, very damaged and often*

quite difficult women. You have got everything from alternative treatments such as massage through to more of the traditional. It is fantastic and it is dealing with all the issues like domestic violence, alcohol, drugs, relationships with children, parenting and so on. It is very, very positive, but expensive. They were given loads of money but the point is it is working. It has only been running for just over a year but I think it is a model that could actually be looked at, but it requires the resources, which is what I am saying there.'

- Problems with mixed-sex wards in hospital which do not meet the needs of women and place them at risk of abuse.
- Training on domestic violence and mental health issues affecting BME women should be compulsory
- Specialist women only advocacy services should be properly funded, and not forced to merge with generic services under commissioning or other pressures
- Need for more research
- Improvements in coroners' services to prevent avoidable deaths.

'Coroners are independent judicial officers and they have more power and autonomy than any other judicial officers. The important thing to know here, if we are making recommendations, [is] that coroners do not actually have any training and they are predominantly white men. They have very little awareness of cultural issues, let alone gender-specific issues and many of them are deeply insensitive to the needs of aggrieved families let alone the community in terms of holding proper investigations where people die in contentious circumstances. There is a whole cultural leap that they are going to have to make as individuals. This fundamental review is supposed to be moving us into the 21st century, and this is an appointment that goes back to the medieval times. They cannot cope with it. They are above educating. You need to have root and branch reform. You need to start all over again…We need to be aware that where a woman dies, if there are really important issues, I think that organisations like SBS, and other organisations, should apply to either be at the inquest or indeed to intervene in judicial reviews. They need to have a voice there that is acting on behalf of the woman herself and indeed the community if that is relevant. Of course expert evidence is important. The whole issue about public funding, there were real problems with funding representation at inquests, and preparation so I think that we should be demanding for (sic) cases that fall in that area. We are not talking about a very large number of cases when you consider it as part of the overall legal aid budget.'

Workshop conclusions

The workshop concluded the following:

- The Government needs to address the gaps in the *Delivering Race Equality* and *Into the Mainstream* documents; the gaps are at the intersection of gender and

race and both these documents, and the implementation and monitoring of them on a local level is missing.

- There need to be more counsellors from within communities and a resource commitment from the DH to provide more long-term counselling.
- Policy and practice should target women with special needs, such as women in special hospitals and refugee women fleeing violence and torture.
- The government should be looking at alternatives to custody and especially around safeguarding against suicide and self-harm in custody
- Local groups should be made more aware of the implementation of local suicide strategies.
- Coroners have a duty to ensure that all the information that is necessary is called forth and made available in cases of self-harm and suicide at inquests, specifically expert evidence, so that lessons can be learned.
- A multi-agency group should be set up within the DH and HO to tackle the high rates of suicide and self-harm amongst BME women with representations from minority women's groups.
- More research on the prevalence of suicide and self-harm amongst minority women, and existing research on South Asian women should be acted on.

Appendix 3

DSM-IV-TR CRITERIA FOR PTSD

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). The diagnostic criteria (Criterion A-F) are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror.

Note: in children, it may be expressed instead by disorganised or agitated behaviour.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.*
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognisable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific re-enactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of

the trauma

4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or without delay onset: Onset of symptoms at least six months after the stressor.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR (Fourth ed.)*. Washington D.C.: American Psychiatric Association.

References

Executive Summary

1. *Report from the Harmful Traditional Practices and Human Trafficking sub-group: Responding to violence against women and children-the role of the NHS*, Taskforce on the Health Aspects of Violence Against Women and Children, March 2010.
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3. State duty to act in order to protect, respect and fulfil human rights.
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5. 'Mature multiculturalism' is a quote from Mike O'Brien, who, in 1999, redefined prevailing multicultural assumptions of non-interference in minority cultures by arguing that state intervention was necessary in order to protect women experiencing forced marriage and other abuse from within minority communities.

Introduction

1. Southall Black Sisters was founded in 1979 to address the needs of black (Asian, African and Caribbean) women to tackle gender based violence. It has developed a nationally recognised expertise on South Asian women and domestic violence. SBS provides holistic resource centre services and undertakes campaigning, developmental, educational, policy and research work to address the underlying causes of violence against BME women. This includes changing social, cultural and religious attitudes and values within minority communities which justify such violence, and influencing legal and social policy, and practice, to improve the state response to the needs of BME women.
2. In 2001, The Diana, Princess of Wales Memorial Fund funded the Project for three years. Later, in 2004, the Bridge House Trust (now re-named the City Bridge Trust) funded the Project for three years with renewed funding for a further two years from 2007. In 2005, the Department of Health also match funded the Project for two years, with renewed funding for one year in 2007.
3. Domestic violence is defined as including physical, sexual, mental and financial abuse. It is a pattern of coercive and controlling behaviour where the perpetrator exerts power and control over the victim. The use of the term 'domestic violence' in this report incorporates harmful cultural/ traditional practices such as forced marriage, dowry-related abuse, female genital mutilation or female circumcision, and so called 'honour based violence', which is abuse committed in the name of family or community honour. Domestic violence is mainly perpetrated by men against women, and is a form of violence against women or gender based violence. This Project includes domestic violence/child abuse against young BME women aged 16-18.
4. Although South Asian women were the predominant group using the services of this Project, other minority groups included African, Caribbean, Middle Eastern and Eastern European women. Also see Appendices 1 and 2 for more information on the experience of other organisations working with a range of minority groups.
5. *Suicide Patterns and Trends in People of Indian Sub-Continent and Caribbean Origin in England and Wales*, V.S. Raleigh, Ethnicity and Health,1996: 1(1): 55-63. Further research is reviewed in *Self-harm in British South Asian women: psychosocial correlates and strategies for prevention*, M I Husain, Waheed & N Husain, Annuals of General Psychiatry 22 May 2006, available on www.pubmedcentral.nih.gov/ articlerender.fcgi?artid=1538599.
6. National Centre for Health Development Outcomes statistics.
7. It is estimated that the domestic violence costs to the country as a whole is £23 billion per annum. This includes an estimated cost of: £3.1 billion to the State; £1.3 billion to the employer; and £17 billion in human suffering. Within this, the cost to the NHS is £1.2 billion (including mental health care estimated at an additional £176 million). See Sylvia Walby, *The Cost of Domestic Violence,* Women and Equality Unit, 2004. This research was updated by Walby in 2009, which showed a reduction in overall economic costs, but these still remained substantial at about £16 billion- see www.lancs.ac.uk/fass/sociology/profiles/34/ .
8. Humanistic psychology tends towards a non-pathologising view of the person. This usually implies that the therapist downplays the pathological aspects of a person's life in favour of the healthy aspects. The aim of much humanistic therapy is to help the client approach a stronger and more healthy sense of self.

9. Cognitive behavioral therapy (CBT) is a psychotherapeutic approach that aims to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure.
10. Psychodynamic psychotherapy is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension.
11. Life coaching is a future-focused practice with the aim of helping clients determine and achieve personal goals.
12. The Battered Women's Syndrome (BWS), originally developed by Lenore Walker, and later developed into the Survivor theory of BWS by E.W. Gondolf & E.R. Fisher, recognises that some victims of domestic violence do escape abuse rather than permanently succumb to feelings of helplessness and diminished perception of alternatives as outlined in the BWS. Walker also argues that the BWS is a subcategory of PTSD as some battered women meet the DSM-IV-TR criteria for PTSD – see Lenore Walker, *Battered Women Syndrome: Key Elements of Diagnosis and Treatment Plan*, Psychiatric Time, Vol. 26, No.7. Also visit: http://www.mamashealth.com/abuse/bwomensyndrome.asp for more information on the BWS.
13. In 2009, the DH established a Taskforce to review the health aspects of violence against women and children.
14. *Report from the Harmful Traditional Practices and Human Trafficking sub-group: Responding to violence against women and children-the role of the NHS*, Taskforce on the Health Aspects of Violence Against Women and Children, March 2010.
15. For example, in the case of 'Jack and Zena', a British/Asian couple who have, for many years, been on the run because Zena's family disapproved of their relationship, and wanted her to marry elsewhere. Zena's family have threatened to kill them and have used community networks, private detectives or 'bounty hunters', so far unsuccessfully, to find them.
16. In one SBS case, when she refused to marry, a young Asian woman was taken to Bangladesh by her family to give her electric shock treatment for her so-called 'mental illness'. SBS managed to prevent this by using contacts in Bangladesh to help her return to the UK before she received the treatment, or was forced into marriage.
17. For example, in 1992, a father and two Muslim priests were involved in the torturing of 20-year-old Kousar Bashir, to death during a ritual exorcism. The woman's father was convicted of murder having acted on the instructions of the priests, who were also found guilty of causing grievous bodily harm. The woman endured eight days of brutal beatings to rid her of an evil spirit called 'John Wayne'. Starved of food and sleep, she was savagely beaten, stamped upon and had hot chilli powder pushed down her throat. Members of her family were told that she did not feel any pain when the beatings were taking place. Also see appendix 1 for the experiences of other BME women in relation to the use of alternative treatments.
18. House of Commons Adjournment Debate on Human Rights (Women), 10 February 1999.
19. *Delivering Race Equality in Mental Health Care*, Department of Health, 1 September 2005.
20. *Women's Mental Health: Into the Mainstream. Strategic Development of Mental Health Care of Women,* Department of Health, 2002.
21. *National Suicide Prevention Strategy for England* Department of Health, London, 2002.
22. State duty to act in order to protect, respect and fulfil human rights.
23. *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: United Kingdom of Great Britain and Northern Ireland,* United Nations CEDAW, forty-first session, 30 June-18 July 2008.
24. This was stated by an SBS service user as part of the evaluation of the Project.
25. *A Bitter Pill To Swallow: Report from WNC Focus Groups to inform the Department of Health Taskforce on the Health Aspects of Violence Against Women and Girls,* Women's National Commission, 2010.
26. *Domestic Violence, Forced Marriage and 'Honour'Based Violence, Sixth report of Session 2007-8, Volume ,* House of Commons Home Affairs Committee, May 2008
27. *Together We Can End Violence Against Women and Girls: A Strategy*, HM Government, 2009
28. *Responding to violence against women and children – the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children,* Taskforce on the Health Aspects of Violence Against Women and Children, March 2010
29. *Interim Government Response to the Report of the Taskforce on the Health Aspects of Violence Against Women and Children (VAWC)*, DH, 2010.

CHAPTER ONE

Building on SBS Advice, Advocacy and Support Services

1 This represents the religious background as described by the client, whether or not the client is practising, a non-believer or agnostic.

2 Karen McVeigh, 'I wish I'd taken her with me', *The Guardian,* 21 July 2007

CHAPTER 2
Developing a BME Gender Hybrid Model of Therapeutic Interventions

1. Life coaching is a future-focused practice with the aim of helping clients determine and achieve personal goals.
2. Originally advocated by Winnicott in relation to child psychology, the 'holding environment' is now widely used to refer to the general therapeutic environment.
3. Humanistic psychology tends towards a non pathologising view of the person. This usually implies that the therapist downplays the pathological aspects of a person's life in favour of the healthy aspects. The aim of much humanistic therapy is to help the client approach a stronger and more healthy sense of self.
4. Cognitive behavioral therapy (CBT) is a psychotherapeutic approach that aims to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure.
5. Psychodynamic psychotherapy is a form of depth psychology the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension.
6. The assessment questionnaire includes questions about simple facts from address and birth date to family situation and reasons for referral. It allows the client to progress gradually from simple questions to more complex issues but also provides the opportunity for them to branch off into details triggered by the questions.
7. The Battered Women's Syndrome (BWS), originally developed by Lenore Walker, and later developed into the Survivor theory of BWS by E.W. Gondolf & E.R. Fisher, which recognises that some victims of domestic violence do escape abuse rather than permanently succumb to feeling of helplessness and diminished perception of alternatives as outlined in the BWS. Walker also argues that the BWS is a subcategory of PTSD as some battered women meet the DSM-IV-TR criteria for PTSD – see Lenore Walker, *Battered Women Syndrome: Key Elements of Diagnosis and Treatment Plan*, Psychiatric Time, Vol. 26, No.7. Also visit: http://www.mamashealth.com/abuse/bwomensyndrome.aspfor more information on the BWS.
8. PTSD has been surrounded by controversy since the beginning with one body of opinion dismissing it altogether and others regarding it as a valid and authentic condition with clear symptoms and markers. Even now, debates and discussions are in progress in the profession, not about its existence as a condition, but rather if it deserves a category of its own and whether it would be more appropriate for it to be included under the wider heading of general trauma particularly for the purpose of DSM V (Diagnostic and Statistical Manual of Mental Disorders produced by the American Psychiatric Association) currently in preparation. The SBS Counselling and Psychotherapy Service has found DSM IV's definitions clear and specific and in the majority of cases very relevant to the experiences and symptoms of many of our clients. It must be stressed that, though this diagnosis is sometimes a significant element of psychological reports, the service does not treat it as a blanket diagnosis but in purely psychological terms as laid down in DSM IV.
9. This is a 3-stage model or framework offered by Egan as useful in helping people 'to manage their problems in living more effectively and develop unused opportunities more fully', and to 'help people become better at helping themselves in their everyday lives.'
10. 'Disclosure' is a technical term in therapy generally referring to what a therapist might reveal.

CHAPTER 3
Addressing and Preventing Suicide and Self-Harm

1. *Suicide Patterns and Trends in People of Indian Sub-Continent and Caribbean Origin in England and Wales,* V.S. Raleigh, Ethnicity and Health,1996: 1(1): 55-63
2. *Attempted Suicide in West London, 1. Rates Across Ethnic Communities* and *Attempted Suicide in West London ll. Inter-group Comparisons of Asian and White Groups,* D. Bhugra et al. 1999
3. See review of some current research on Asian female suicide in *Self-harm in British South Asian women: psychosocial correlates and strategies for prevention*, M I Husain, Waheed & N Husain, Annuals of General Psychiatry 22 May 2006, available at www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1538599
4. See *Self-harm in British South Asian women*
5. See *Suicide Patterns and Trends*
6. See *Women's Mental Health: Into the Mainstream,* Department of Health, 2003. Also, see *Responding to violence against women and children-the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children,* Taskforce on the Health Aspects of Violence Against Women and Children, March 2010
7. *Saving Lives: Our Healthier Nation,* Department of Health, London, 1999.
8. *National Service Framework for Mental Health* Department of Health, London, 1999.
9. *National Suicide Prevention Strategy for England*

Department of Health, London, 2002.

10. National Centre for Health Development Outcomes statistics.
11. See *Suicide rates in people of South Asian origin in England and Wales: 1993*-2003 in The British Journal of Psychiatry (2008) 193, by McKenzie el al, which argues that suicide rates have fallen for all groups, and that, although older Asian women aged over 65 have a suicide rate double that of England and Wales, young South Asian women are no longer at increased risk of suicide. However, the methodology used in the study was questioned by leading epidemiologist - see letters by Raleigh on 10 February 2009 and Aspinall on 10 February 2009 in response to the study in The British Journal of Psychiatry.
12. *The Richard and Judy Show*, Channel 4, 26 April 2002.
13. *The Scotsman* Newspaper, 8 April 2000.
14. Martin Wainwright ''High Suicide Risk' for Asian Women', *Guardian,* 27 April 1996.
15. Although the Coroner has argued that this passage is a preamble to the verdict, the matter is disputed by Rajdeep's solicitors and family who argue that it forms part of a narrative verdict.
16. This quote is from a note by SBS at the Inquest and is not verbatim.
17. Clare Lomax, 'Tragic Wife Hanged Herself in Her Home', *Telegraph and Argus*, 4 May 2002.
18. State obligations to act in order to protect, respect and fulfil human rights.

CHAPTER 4

Improving Policy and Practice – The Way Forward

1. Evidence by SBS service user in 2009 to focus group for the DH Taskforce on the Health Aspects of Violence Against Women and Children.
2. The Fawcett Society reported that black people with mental health problems are likely to stay longer as in-patients in psychiatric wards, and are more likely to be prescribed medication or electro-convulsive therapy in their publication, *Black and Minority Ethnic Women in the UK,* 2005.
3. See Appendix 1.
4. Evidence by SBS service user to DH Taskforce.
5. ibid.
6. Such as the Home Office National Delivery Plan on Domestic Violence 2009-10, the Sexual Violence and Abuse Action Plan and the national strategy on Violence Against Women and Girls 2009.
7. *Delivering Race Equality in Mental Health Care*, Department of Health, 1 September 2005.
8. Prof S.P. Sashidharan, *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, National Institute of Mental Health, 1 March 2003.
9. *Delivering Race Equality: A Framework for Action,* Department of Health, October 2003.
10. For example, the Birmingham and Solihull Mental Health Trust helped to establish a project which trains Imams to provide counselling- see Nadeem Badshah, *Imams also counsellors: New Mental-Health Initiative,* Eastern Eye, 2 May 2008.
11. *Women's Mental Health: Into the Mainstream. Strategic Development of Mental Health Care of Women,* Department of Health, 2002.
12. *Mainstreaming Gender and Women's Mental Health: Implementation Guidance,* Department of Health, 2003.
13. *Tackling the health and mental health effects of domestic and sexual violence and abuse,* Department of Health , 2006.
14. *Healthier, Fairer and Safer Communities-Connecting People to Prevent Violence: Towards a Framework for Violence and Abuse Prevention,* Department of Health, 2008.
15. The ecological framework recognises that individual violence and abuse take place in a context of a wider eco-system of individual, personal relationship, community and societal factors, including socio-economic deprivation, discrimination, building design and layout, excess alcohol consumption and adverse childhood events amongst many others.
16. The Department of Health states that the Family Intervention Programmes have been successful in reducing domestic violence. More evaluation needs to be done on the level, severity and type of violence these programmes have reduced and how this has impacted on BME women.
17. *National Suicide Prevention Strategy for England* Department of Health, London, 2002.
18. Glen Owen and Oliver Wadeson, *'Abused' Asian Women Behind Soaring Toll of Track Suicides,* The Mail on Sunday, 23 September 2007.
19. Department of Health press release, Government News Network on www.gnn.gov.uk, 10 October 2007.
20. *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care* Clinical Guidelines 16, NICE (developed by the National Collaborating Centre for Mental Health).
21. *Truth Hurts: Report of the National Inquiry into Self-harm among Young People,* Mental Health Foundation and Camelot Foundation, 2006.
22. *Domestic Violence* Council Report CR102, Royal College of Psychiatrists, London, April 2002.
23. For example, *Responding to Domestic Abuse: A handbook for health professionals,* Department of Health, 2006.
24. *Children, Young People and Domestic Violence: A*

Practical Toolkit, Department of Health, 2009.
25. *Together We Can End Violence Against Women and Girls: A Strategy*, HM Government, 2009.
26. *Domestic Violence, Forced Marriage and 'Honour '-Based Violence, Sixth report of Session 2007-8, Volume 1* House of Commons Home Affairs Committee, May 2008.
27. *DH Taskforce on the Health Aspects of Violence against Women and Girls: Emerging Findings,* Department of Health, November 2009.
28. The 'No Recourse to Public funds' rule affects non-British spouses whose marriage to British citizens is subject to a probationary period of two years. If the marriage breaks down during this period, the non-British spouse will not be able to claim benefits or get access to public housing until they obtain indefinite leave to remain.
29. *Responding to violence against women and children-the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children,* Taskforce on the Health Aspects of Violence Against Women and Children, 2010.
30. *Report from the Harmful Traditional Practices and Human Trafficking sub-group: Responding to violence against women and children-the role of the NHS*, Taskforce on the Health Aspects of Violence Against Women and Children, 2010.
31. *A Bitter Pill To Swallow: Report from WNC Focus Groups to inform the Department of Health Taskforce on the Health Aspects of Violence Against Women and Girls,* Women's National Commission, 2010.
32. *Report of the Domestic Violence sub-group: Responding to violence against women and children- the role of the NHS,* Taskforce on the Health Aspects of Violence Against Women and Children, 2010.
33. *Interim Government Response to the Report of the Taskforce on the Health Aspects of Violence Against Women and Children (VAWC)*, DH, 2010.
34. *New Horizons: A Shared Vision of Mental Health,* HM Government, 2009.
35. *The Way Forward: Taking action to end violence against women and girls, Final Strategy 2010-13,* Mayor of London, March 2010.
36. *Death Certification and Investigation in England, Wales and Northern Ireland. The Report of a Fundamental Review 2003*, Presented to Parliament by the Secretary of State for the Home Department, June 2003.
37. *Certifying and Investigating Deaths in England, Wales and Northern Ireland. An Invitation for Views*, August 2002.
38. *Reforming the Coroner and Death Certification Service. A Position Paper*, Home Office, March 2004.
39. *Coroners Service Reform. Briefing Note*, Department of Constitutional Affairs, February 2006.
40. Tania Branigan, Clare Dyer and Audrey Gillian, 'Coroners to get new powers to prevent avoidable deaths'*, The Guardian*, 30 January 2007.
41. *Draft Coroners Bill: Analysis of Security by Bereaved People's Panel. 9 November 2006*, Department of Constitutional Affairs, February 2007.
42. Quoted by Catherine Atkinson, ' Ending the cycle of domestic violence', *The Guardian,* 24 July 2006 accessed at http://www.guardian.co.uk/society/2006/jul/24/crime.penal on 23 July2010
43. *Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004*, Home Office, June 2006.
44. This was stated during the passage of the Act through Parliament.
45. *Southall Black Sisters' Response to Consultation on Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004,* Southall Black Sisters, September 2005
46. ibid.
47. Southall Black Sisters Submission to the Law Commission Consultation Paper No 177, May 2006.
48. *A New Homicide Act for England and Wales? A consultation paper No 177,* Law Commission
49. Under English law, a person is guilty of involuntary manslaughter when he or she intends an unlawful act that is likely to do harm to another person, and death results which was neither foreseen nor intended.
50. R v Harcharan Dhaliwal, 7 March 2006, Central Criminal Court.
51. ibid.
52. Hansard Debates for 18 October 2006
53. Pukaar is part of Ethnic Alcohol Counselling in Hounslow (EACH).
54. This clinic, which deals with many FGM cases, is faced with closure as a result of mainstreaming.
55. *South Asian Women: exploring systemic service inequalities around attempted suicide and self-harm* Khatidja Chantler, Erica Burman and Janet Batsleer European Journal of Social Work, Vol 6, No 1, 2003.

Evaluation

1. *Report from the Harmful Traditional Practices and Human Trafficking sub-group: Responding to violence against women and children-the role of the NHS*, Taskforce on the Health Aspects of Violence Against Women and Children, March 2010.

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