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Stella Project

Equality and diversity

Section 10

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Survivors of domestic and sexual violence who also have problems with substance use and/or mental ill-health often report in barriers to accessing services. Survivors may, for example, not be able to access some refuges or mental health services if they drink problematically or use drugs.

These difficulties can be compounded by inappropriate reactions to the survivor's identity, including age, gender, ethnicity, culture, class, sexual orientation or ability. Furthermore, each survivor's unique identity will affect her confidence and ability in seeking help, reduce options for support, increase the risks of leaving an abuser or reporting a perpetrator to the police, or otherwise affect the choices which she can make.

By being more aware of these issues, you will be able to make your service more accessible to survivors from many different parts of society. This section provides some guidance on working with survivors of different ages, ethnicity, ability and sexual orientation, but the information is not exhaustive. Further guidance can be found in appendix H.

9.1 General guidelines for addressing diversity

- Be aware that perpetrators will exploit different characteristics or experiences the survivor has. For example, if the survivor has limited mobility due to being physically disabled, the perpetrator may remove mobility devices that enable independence.

- Remember that a survivor's ethnicity, culture, gender, age, sexual orientation, ability and/or class may affect how and when she seeks help and the type of support she needs.

- Everyone is a unique and multi-faceted individual. Whilst one person's sexuality or ethnicity, for example, is an integral part of how they see themselves and live their life, it may not be the same for the next person. Do not make assumptions about what might be important or relevant to a survivor.

- Remember how much diversity exists within groups of people. 'Asian' people, for example, are not a homogenous group. Neither are all lesbians. Viewing people on the basis of one characteristic, such as their gender or sexuality, is simplistic and can perpetuate unhelpful and inaccurate stereotypes.

- Whilst it is important to find out how you can best support and assist a survivor, be careful not to use her as a reference point or learning resource about, for example, her culture or sexuality if this is new to you. If you want to learn more about, for example, survivors who are physically disabled, do your own research or look into training courses.

- Find out whether a survivor wants to be signposted or referred to a specialist organisation or would prefer to access mainstream services. It is possible that she has not told family or friends about her sexual orientation or mental health difficulties and thus does not want to use services specifically aimed at survivors who are lesbian, gay, bisexual or transgender (LGBT) or who have problems with their mental health.

- Think about and ask what is the most suitable format for your communication. Do not assume everyone is literate. You should also consider whether you need to provide information for someone in a different format for example, in large type or on audio tape. You may need to talk through information with some people rather than just hand it to them.

- Survivors who are also affected by substance use and/or mental ill-health and are also, for example, from a minority ethnic group or are physically disabled may need assistance from several different agencies. Special care must be taken to ensure the survivor is not disempowered or overwhelmed by multi-agency involvement.

- Some survivors from the groups referred to in this section may find it difficult to manage the very practical aspects of living away from their partner. Survivors, for example, who do not speak English as their first language, who are illiterate, are learning

disabled and possibly also older and younger survivors may struggle with managing unfamiliar finances, coping with tenancy agreement regulations, negotiating complex bureaucracies in terms of applying for benefits and housing. Additional on-going support to enable survivors to live independently may be needed.

- Be aware of the Equalities Act 2010. The Act brings together all the legal requirements on equality that private, public and voluntary sector bodies need to follow. The provisions in the Act mean that everyone has the right to be treated fairly at work or when using services. As a service provider, you should be aware what actions you are required to take to prevent discrimination or harassment of employees or service users who have a 'protected characteristic'. These characteristics are: disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation and age. Full information about the Act and the related Duties can be found on the EHRC (Equality and Human Rights Commission) website: http://tinyurl.com/37h8yep.

9.2 Improving access to services

The following pages provide information about the main equalities groups: younger and older women, survivors from minority ethnic and cultural groups, survivors who are physically or learning disabled, male survivors and those who define themselves as being lesbian, gay, bisexual or transgender.

As already mentioned, this is not an exhaustive list of guidance, but a starting point. Each survivor is unique and is the best person to explain

9.2.1 Survivors of different ages

Women of all ages are abused. Both younger and older women are not always believed or listened to when they speak about their experience of domestic violence. As survivors of different age groups may have differing needs, the information below is split into younger and older women.

Younger women

- Young women may experience violence from a partner as well as parents, siblings, family friends, etc.

- They may find it difficult to disclose violence from other family members and may fear the consequences of taking any action.

- Young women may not be used to having access to legal remedies or exercising their rights so may need support to do so.

- Due to limited access to welfare benefits and housing, 16-18 year olds can find it difficult to flee family members or a partner who is abusive. As such, they are at higher risk of running away and thus more vulnerable to sexual exploitation when homeless.

- Young survivors' mental health needs should be assessed by services. Self-harm is most common amongst people between the ages of 11 and 25, with between 1 in 12 and 1 in 15 young people deliberately harming themselves.[1] Young women, in particular, can become trapped in a cycle of self-harming in order to manage trauma responses.

- Young men, by contrast, tend to externalise intrusive thoughts by acting out aggressive patterns and through involvement in risky activities.

Older women

- Older women may find it difficult to speak to a younger woman.

- Some older women may feel they have coped with violence so long, it is not worth making difficult changes.

- Some older women may be embarrassed about having put up with the violence for so long and may try to underplay it.

- Older women may experience abuse from a partner who is also their carer. They may fear losing their home, support or independence, especially if institutional care is the only option. Conversely, the survivor may be the perpetrator's carer and may feel a duty to care for him, especially if otherwise he will have to go into a home.

- Older women's mental health needs may not be well recognised. Depression affects one in four people over 65, and one in two people over 85. Women over 75 are more likely to commit suicide than any other group of women.

- Survivor's mental health problems may be ascribed to getting older, rather than surviving violence or abuse. Perpetrator's abusive behaviour can be masked by mental health problems such as Alzeihmer's Disease, which is more common in older people. In cases where an older person develops Alzeihmer's and uses violence or aggression, professionals should talk to family members about any history of violence or other types of abuse.

- Older survivors may be drinking, using prescribed medication or illicit drugs in a way that is problematic, but similarly to mental health, this issue may not be recognised or addressed. Professionals should be pro-active in asking about levels of substance use.

9.2.2 Developing culturally specific services

Domestic and sexual violence happens in every part of society, including among people from different ethnic and cultural backgrounds. Similarly, problematic substance use and mental ill-health is not confined to one social group.

In addition to experiencing domestic and sexual violence, women (and a smaller proportion of men) from ethnic and cultural minorities may also be at risk of other types of violence:

- **So-called honour crimes.** So-called 'honour' crimes stem from the belief that women are the upholders of honour in a family and their behaviour is a mark of family honour. Dishonouring, or bringing shame on, the family is responded to with violence, abuse and sometimes even murder.

- **Forced marriage.** In comparison with arranged marriages, in which both parties agree to the marriage, forced marriage involves one or both parties not consenting to the marriage or consenting under duress.

- **Female genital mutilation (FGM).** FGM is the procedure partially or completely remove the external female genitalia for non-medical reasons. It is most commonly practiced by certain ethnic groups who live mostly in Africa and the Middle East. Due to migration, FGM is now practiced by ethnic minority populations

around the world. It is estimated that around 6,500 girls are at risk of FGM within the UK every year.[2]

All forms of violence can be complicated by multiple family members who collude with or are directly involved in the violence. Survivors from ethnic minority populations, particularly where the perpetrator has links to another country, also have greater fears about child contact and the threat of child abduction.

There is evidence that BAMER survivors might manage responses to abuse and trauma differently than their White British counterparts. Use of alcohol and drugs appears to be lower among Asian, Afro-Caribbean and Traveller women than White British women, although it is on the increase.[3]

Conversely, there is evidence that BAMER women are considerably more likely to self-harm and attempt suicide than White British women and Asian men.[4] South Asian women who self-harm are also less likely than White British women to have a psychiatric disorder, and are more likely to cite marital or family problems as the reason for self-harming.[5]

Whilst individual survivors' experiences of violence and abuse will vary greatly, as will their needs, there are also some similarities in the barriers survivors' from ethnic minorities may experience in accessing support. These are outlined below along with suggestions of how professionals can develop a multi-cultural approach to working with survivors who are affected by substance use and/or mental ill-health.

Experiences of discrimination

Survivors from ethnic minorities may be wary of involving the police, the legal system, social services or health services because of discrimination and racism within institutions. Research with first and second generation Asian women living in the UK, for example, found that 65% had experienced racial harassment and 35% reported sexual discrimination.[6] Among Travellers there is strong anecdotal evidence of being openly discriminated against and refused access to primary health care on the basis of their surname and address (both of which identified them as Travellers).[7]

In relation to domestic and sexual violence, this can result in survivors being wary of approaching the police, unsure of their reception, whether they would be treated with respect and fearful of how their partner would be treated by the police and the courts.

Lack of cultural awareness

A lack of knowledge about different cultures within minority communities can also be a barrier to understanding survivors and ascertaining what they need. Analysis of serious case reviews have highlighted professionals' tendencies to stereotype families from different ethnic or cultural backgrounds, combined with misinterpreting what parents say, can have a negative impact on social work assessments and judgments.[8]

It is therefore very important for professionals to find out more when survivors' behaviour does not match *our* expectations, fit in with ***our*** cultural norms or does not make sense *to us*. For example, some women may not want to bath when menstruating which means that in accommodation without a shower, a survivor may not wash for a few days which could be viewed by staff as self-neglect. Alternatively, religious or cultural beliefs may forbid divorce, with divorced women experiencing severe stigma. For some survivors, the stigma of being divorced may outweigh the possible advantages and thus advice to divorce may not be acted upon.

Furthermore, many cultures continue to operate along rigid gender divide. Female survivors may feel uncomfortable talking to men about personal problems, and so a choice of professionals should be offered. This includes GPs, solicitors, social workers, mental health workers and the police.

Communication

Being able to communicate clearly with professionals is vital for survivors. For survivors who do not speak English as their first language and are not able to communicate clearly in English, professionals should use an interpreter (guidance for working with interpreters is on p.228). Interpreting services should also be made available to people who are deaf or deaf blind (information about national services can be found in appendix H).

All advice and information should be provided in the survivor's first language, wherever possible, and also in a format that is accessible. This means professionals should not assume that someone can read. An estimated 62% of Travellers, for example, are illiterate[9], and many people who may have learnt to speak English might not be able to read or write well. This includes being able to read letters about appointments, etc. which should be sent and followed up with a telephone call to confirm the person has understand the content of the letter.

Attitudes towards and treatment of mental ill-health

Sadly there are varying levels of understanding about, and stigma attached to, having mental health problems.

In some groups, for example Traveller communities, there are high levels of stigma and fear around mental health. Stress, anxiety and depression are seen as 'bad nerves' and part of every day life which Travellers may not consider approaching their GP or mental health services for help. 'Mental health' refers to more severe problems such as psychosis.[10]

Survivors of Asian heritage may also be reluctant to speak to a GP about difficulties with their mental health for fearing of bringing shame on the family, not being a "good" Asian wife and mother, and of being considered "pagal" (mad).[11] Similarly to other survivors, Asian survivors may present to their GP with somatic symptoms such as headaches, other aches and pains, feeling constantly tired, low and tense. Practitioners, including GPs, should be aware that these could be symptoms of psychological distress and ask more directly about mental health problems.[12]

Afro-Caribbean people may also be more inclined to manage their mental health themselves and not seek assistance until more acutely unwell. Research[13] has found that Afro-Caribbean people are less inclined to see a GP before presenting as an acute patient to A&E and are more likely to be admitted by the police. Being detained by the police may reflect discrimination and racism, but could also point to Afro-Caribbean people being less likely to access early intervention for mental health difficulties. This could be, in part, because of beliefs about the causes of mental ill-health. A large body of

research has shown that individuals from different cultures attribute the causes of mental illness to a variety of factors, including curses and spirit possession. If you understand what is happening to be the result of a curse rather than responses to trauma, you are less likely to ask your GP for help.

Sense of community

Survivors from ethnic and cultural minorities may have people in their community who will support them, including through women's groups. At the same time, strong community connections and the communication that often exist within smaller communities may exacerbate survivors' attempts to protect themselves from domestic or sexual violence, or to get support for mental health/substance use problems.

Due to limited privacy, particularly if sharing accommodation with extended family members, survivors may find it difficult to research support services or attend appointments. Being seen at a GP surgery, for example, may raise suspicions and have negative connotations.[14] There may also be a strong tradition of dealing with problems within the family or the community, rather than asking for outside help from professionals[15].

The strong sense of community may also lead to survivors from ethnic or cultural minorities feeling like they have too much to lose by leaving an abusive partner. If a survivor does decide to leave, she may have to leave the whole community, which means losing contact with her culture and way of life.

Professionals therefore need to address survivors' relationships with their community, identify ways in which the community provides support and consider alternative sources of help and assistance.

Immigration status and recourse to public funds

Migrant women may fear losing their right to stay in this country if they separate from an abusive partner and may have been threatened with this. This can mean that official agencies (not only immigration but also the police and social services) may be seen as particularly threatening to a survivor if her immigration status in insecure. Furthermore, asylum-seeking women and

undocumented migrants are even more marginalised than migrant women generally and even less likely to access services

Most survivors with insecure immigration status have no recourse to public funds. This means they are unable to access state benefits such as housing benefit which pays for temporary accommodation, including refuge. Without access to any money or accommodation away from the perpetrator, survivors without recourse to public funds are among the most vulnerable members of society.

If you are working with a survivor who has no recourse to public funds, contact Rights of Women (details on in appendix H) or the No Recourse To Public Funds Network (www.nrpfnetwork.org.uk or 0207 527 7121).

9.2.3 Guidelines for working with interpreters

For survivors whose first language is not English, you may need to use an interpreter. Talking about sensitive and emotional issues like violence and abuse, substance misuse and mental ill-health is very difficult to do in a second language.

Below are some guidelines to help you select and use an interpreter:

- Always use a professional interpreter; never use a survivor's partner, child, friends or family member.

- Be sensitive to the fact that for some women, the use of a male interpreter may preclude any discussion of certain subjects so whenever possible, try to use a female interpreter. If, in an emergency, this is not possible don't press for details if you sense a discomfort in talking about sensitive issues. Try to arrange another time when a female interpreter is available.

- Try not to use interpreters from the client's own local area or from community associations to which she, her husband, family or friends may belong. If in doubt, ask.

- Make sure that interpreters sign a confidentiality clause in their contract with you and that they understand the necessity for such precautions.

- Ensure that the interpreters have been trained in issues of domestic

violence and that they don't have strong beliefs about the 'sanctity of marriage' or that 'outsiders' should not interfere within 'their' community.

- If you regularly use interpreters, include them in any training you may have on domestic violence, substance use or mental health.

- Before any interpreting begins, ensure that language and dialect match between the interpreter and the client.

- During the session, allow time for introductions, pause frequently so that the interpreter can easily remember and translate what you are saying.

- Make sure the interpreter understands that their role is to interpret, not to advise, censor or summarise what either you or she is saying.

- Look at the client and speak directly to them, not the interpreter.

9.2.4 Supporting disabled survivors

Disabled survivors are harmed by partners, relatives, carers or personal assistants and experience additional abuses that use and exploit the impairment, for example threatening to have them institutionalised; controlling disability aides such as wheelchairs or medication; refusing to wash, toilet or feed them; refusing to help them until they consent to sex; making decisions on their behalf without their consent and restricting access to communication aids and their ability to contact others. In relation to people who are learning disabled, abusers are also usually someone involved in the person's care, and the survivor is less likely to disclose the abuse to services.[16]

When supporting survivors of domestic and sexual violence who are disabled, be aware of the powerful myths that determine the way view disabled women. For example:

- Disabled women are imperfect, dependent, weak and helpless - a crime against them is not of the same magnitude.

- Disabled people do not have partners so cannot be abused by them.

- The survivor needs the aggressor's care and has 'chosen' to remain dependent.

- Disabled people are 'asexual' so would not be sexually exploited, abused or raped.

In fact, there is research evidence that disabled people are at least twice as likely to be abused than non-disabled women.[17]

Key points to bear in mind when supporting survivors who have problems with substance use or mental ill-health and are disabled:

- A disabled woman may feel dependent upon the abuser for 'care' and the home which may have been specially adapted. This makes leaving a very difficult option – she will need information about alternative sources of care.

- She may fear isolation at home, or not wish to live in institutional accommodation. It is important to acknowledge that there are few alternative sources of support.

- She may fear losing her children. This is particularly relevant for parents who are learning disabled. There is, however, no research that supports the argument that parents who are learning disabled are poor parents, and in a large number of families receiving social care interventions also involve domestic violence and drug/alcohol problems.[18]

- She may feel that a non-disabled person would not understand or empathise. She may wish to have contact with disability groups taking up the issue of violence.

- Accessing services can be more difficult for disabled women. Services may not appreciate women's needs, provide appropriate care or access requirements. Disabled women's experiences should be a mandatory part of any service planning; to exclude them constitutes discrimination.

It is also important to remember that disabled survivors may well have the same responses to trauma as non-disabled survivors and may also use substances to manage. Self-harm among people who are learning disabled, for example, is thought to be quite common.[19]

Disabled survivors may also be regarded as a vulnerable adult (more information on p.114). In this case, professionals may wish to contact their local safeguarding adults team for advice on what action to take.

9.2.4 Supporting male survivors

Men can also be victims of domestic violence at the hands of a female partner and adult children, siblings and carers. Many men may feel embarrassed or ashamed about the abuse they are experiencing, as it does not fit common masculine stereotypes. This may make it difficult for them to disclose the violence and seek appropriate help.

There is limited research and work undertaken on the needs of male victims but what is clear is that it is not appropriate to develop services for male victims as a mirror image of female services. Evidence also suggests there are different support needs for men and this differs between heterosexual and homosexual men.

As with any survivor, it is important to find out what support male survivors would like. More often they seek practical assistance rather than emotional support, but this may vary. Practitioners working with male victims of domestic violence are encouraged to call the Men's Advice Line (in appendix H) who can provide information about how to screen survivors to ensure they are not perpetrators and can tell you where to signpost or refer male survivors to. They have a new toolkit for working with male survivors, which can be downloaded here: http://tinyurl.com/ak7ntku.

Male survivors of sexual violence should be signposted to the nearest SARC (more information in the glossary) and the Survivor's Trust for details of local support (in appendix H).

9.2.5 Working with Lesbian, Gay, Bisexual and Transgender communities

Rates of domestic and sexual violence appear to be higher amongst lesbian, gay, bisexual and transgender (LGBT) people than in the heterosexual population. Estimates of prevalence vary, but limited research[20] has found that:

- Similar proportions of lesbians and gay men may have experienced domestic violence from same sex partners, and lesbians have also

experienced domestic violence in earlier relationships with male partners.

- Gay men are significantly more likely to experience physical and sexual violence, while lesbians are much more likely to be affected by emotional and sexual abuse.

- Transgender people are particularly vulnerable to domestic and sexual violence and that both are commonplace but relatively unspoken of within the trans community.

Many experiences of domestic violence are the same regardless of the survivor's sexual orientation or gender identity. There are, however, some differences to be aware of:

- The abuse may be perpetrated by other family members, for example, when someone discloses their sexual orientation or gender identity.

- The perpetrator may use the threat of 'outing' the survivor to their family, friends, colleagues as a means of control. Conversely, survivors may be forced to not out themselves.

- For gay men, there is a higher risk of being infected with HIV if they are unable to negotiate safe sex. Perpetrators may also threaten to reveal their HIV status to others.

- Survivors may be told that abuse is a normal part of same-sex relationships.

- Mental health problems and self-harming is more common among LGBT people, often linked to difficulties in coming to terms with their sexual/gender identity and/or experiencing homo/bi/transphobia.[21] GPs and mental health workers should be aware that these mental health problems may also be responses to the trauma of experiencing domestic and sexual violence.

- There is inconclusive evidence about levels of substance use among LGBT people. There are arguments that substance use is higher due to the central role that bars and clubs can occupy for many LGBT people. An alternative explanation is the impact of homo/bi/transphobia and heterosexism, which may exacerbate the use of alcohol and other substances as a coping mechanism for dealing

with discrimination. Substance use may also be a strategy for managing trauma responses. Services should be aware of all three possibilities and talk to the survivor about how and why they use.

There are also specific barriers to accessing support for domestic and sexual violence, substance use and mental health which include:

- The need to 'out' oneself to access services or to discuss how violence and abuse is impacting on alcohol, drug or mental health problems
- Real or perceived homo/bi/transphobia (remarks, gestures, verbal and physical abuse and harassment) from service providers.
- Fear that what you say may be used to criticise or condemn all non-heterosexual relationships
- The potential impact of internalised homo/bi/transphobia
- Concerns that the perpetrator will encounter homo/bi/transphobia from police stops survivor reporting abuse
- Unsafe practice in many services due to the fact that staff are unaware that an accompanying 'friend' of a service user could be an abusive partner
- In relation to domestic violence, LGBT survivors may not think the law applies to them
- A lack of appropriate or specialist services (particularly access to crisis housing provision). Broken Rainbow offers support and advice to LGBT survivors. Their details are in appendix H .
- Fear of condemnation and being ostracised from within the LGBT community
- Controlling substance use or remaining abstinent often requires staying away from the drug, alcohol or party 'scene' which the survivors may rely on to meet other LGBT people. This could give rise to fears of isolation and not meeting a new partner/LGBT friends.
- Possible lack of support from family or friends

Some useful guidelines on LGBT affirmative practice:

- Develop a comfortable appreciation of your own sexuality and sexual orientation.
- Explore survivors' experiences of oppression with them.
- Help your client to be aware of stereotypes about their sexual orientation and/or gender identity.
- Explore issues, possibility and consequences of "coming out".
- Explore anger and safe ways of expression.
- Depression is very common so work with denial of anger, denial of self-validation and "emotional fatigue" from being invisible and deep hurts caused by homo/bi/transphobia.
- Encourage the survivor to establish a LGBT network system of support, nurturing, care and respect.
- Give messages that are affirming, respectful, valuing and accepting of the survivor's sexual orientation and/or gender identity.
- Desensitise shame and guilt surrounding LGBT thoughts, feelings and behaviours.
- Support consciousness raising efforts.