Practice Seminar Summary
Gender Based Violence and Black and Minority Ethnic (BME) Women's Mental Health

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About AVA

Against Violence and Abuse (AVA)

AVA is a charity working to end gender-based violence. With a mission to inspire innovation and collaboration and encourage and enable direct service providers to help end violence against women and girls, it has a demonstrable track record of effecting practical change within service delivery as well as changing policy. It has particular strength in leading innovative projects which address the complexity of issues relating to Violence Against Women and Girls (VAWG).

Multiple Disadvantage

AVA has pioneered work around women facing multiple disadvantage, working to address the overlapping issues of gender based violence and abuse, drug and alcohol use, mental health and homelessness and the removal of children. We work for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators.

For further information on any of the issues covered in this briefing please contact Dr Lucy Allwright, Project Manager lucy.allwright@avaproject.org.uk.

Introduction

On May 8 2017, AVA held a seminar to explore the theme of gender-based violence and BME women's mental health. The seminar provided an opportunity to explore existing models, barriers and challenges, to hear from experts by experience and explore solutions to barriers.

This summary brings together the key points from the seminar – it is not intended as a definitive guide but as a summary of the views and ideas put forward on that day.

The event was part of a series of seminars being funded by Trust for London as part of the Access to Safe Housing project improving access to refuges and accommodation for women facing multiple disadvantage. As part of this project AVA has been working with three specialist BME refuges. In conversation with refuge staff it was felt that more space was needed to explore BME women's experiences of mental ill health and of the mental health system. In particular in recognition that BME women's needs are impacted by racism and discrimination. This event offered an opportunity to bring together around 30 BME women from a range of sectors, particularly from BME VAWG specialist services, to explore experiences and ideas.

With thanks to Asha Projects, particularly Saima Khan, who helped organize the seminar.

Key objectives for the day:

- To consider (BME) women's experiences of mental ill health in light of trauma and abuse in relation to Domestic Violence.
- To consider conflicting models of interpreting women's mental health – the medical model, spiritual models, experts by experience perspectives.
- To explore ways services can improve their responses to (BME) women.
- To exchange knowledge, practice and ideas and come up with an action plan for services.
- To create a BME women's mental well-being policy that could be used by services.

Speakers:

- Dr Jayasree Kalathil, independent researcher, writer and mental health activist, Survivor Research, London
- Baljit Banga, Director of London Black Women's Project
- Savin Bapir Tardy, Counselling Psychologist, IKWRO
- Parveen Betab, Women and Girls Network, Project Coordinator - IPAMO House of Healing
- Chaired By Shabana Kausaur, Violence Against Women and Girls Coordinator, Haringey Council

Definitions and a note on language

During the event a number of points came up around the language used to describe mental health and distress, reflecting that the event brought together people from gender-based violence services and mental health services. For some these ideas were a new way of thinking about mental health.

- Mental Health, Mad and Madness: Dr Jayasree Kalathil is part of the mental health survivor movement. She identifies as a 'survivor' of societal structures that create mental distress as well as the psychiatric system that pathologises distress. Jayasree calls for a reclaiming of the word mad and questions stigmatised and negative opinions. Reclaiming mad is part of an intersectional approach which places madness alongside other social inequalities such as gender, ethnicity, social class, age, disability etc.[1] While this summary continues to use the term mental health it does so in recognition that the term mental health is loaded – related to the history of mental health responses and the experience of those who have survived those systems.

Structure

The event was focussed on conversation and giving those present space to discuss and explore. The morning was structured around two panels: models of mental health and voices from the frontline. The rest of the event offered space for people to explore the barriers and challenges to supporting survivors and accessing services and to consider what good practice models might look like. The first part of this summary pulls together the key themes from the morning presentations and conversations. The second part summarises the ideas that emerged in terms of good practice as well as good practice asks.

Key Themes

A number of key themes emerged from both presentations and in conversation on the day. These are summarised below.

[1] 'Mad and Queer studies: interconnections and tensions,' Mad Studies Network https://madstudies2014.wordpress.com/2016/07/01/mad-and-queer-studies-interconnections-and-tensions/ (accessed, 05/07/2017)

BME Women's Experiences

Distress and recovery are not individual experiences

Speakers and participants explored the social context of BME women's mental distress and how this links to VAWG. However, it was felt that BME women's experiences were not understood by mainstream services, particularly by the health systems women encountered.

- Jayasree Kalathil Summarised her research in collaboration with the Mental Health Foundation to explore distress and recovery through interviews with African, African Caribbean and South Asian Women.[2] A key finding was that for many women mental distress was a response to specific experiences yet there was a lack of understanding about the context of BME women's mental distress when they presented to mental health services. Women's pre-stories were not being taken into account by mental health services and so women's experiences of violence and abuse were ignored.
- It was also explored how particular events impact on BME women's experiences of domestic violence, Baljit Banga commented: 'you cannot unpick women's experiences – certain events like Brexit or an attack on a city. After an attack women cannot leave the house. So after a terrorist attack women fear leaving the house so this impacts on domestic violence as they cannot escape.'
- Race is a critical issue for BME women accessing support for mental distress. London Black Women's Project (LBWP) have found that:
    - People felt judged in accessing services.
    - Practitioners did not understand their context or history.
    - No one was asking about the causes of self-harm, for many women this was a response to VAWG. It wasn't being asked when women accessed services.
    - Race was a non-existent category in mental health services – it was only recorded as a demographic category.
    - VAWG was a non-existent category in mental health services.
    - Mental health services were not intersectional.
- Jayasree also explored the difficulties BME women face in questioning their own communities: many women are held in bind because questioning their experience may then be used to confirm racially and culturally biased assumptions about that particular community.

[2] Jayasree Kalathil, Beth Collier, Renuka Bhakta, Odete Daniel, Doreen Joseph and Premila Trivedi. 'Recovery and Resilience: African, African Caribbean and South Asian Women's Narratives of Recovering from Mental Distress. London: Survivor Research and Mental Health Foundation, 2011. https://www.mentalhealth.org.uk/sites/default/files/recovery_and_resilience.pd (Accessed May 1 2017)

The Medical Model and health approaches

In the clinical space there is no record of BME women's experiences

Participants explored BME women's experiences of the clinical model of mental health. This built on the conversation around BME women's mental distress.

- 'In the clinical space there is no record of BME women's experiences. Clinical categories create records so we lack records on BME women because their experiences are not recognised.'
- LBWP found in research with South Asian women that services viewed them as not engaging. LBWP started to monitor this. Found that women were disengaging because they were not engaged with the approach offered.
- It was discussed that women are more likely to be diagnosed with Borderline Personality Disorder (BPD) than men, the main cause of BPD is trauma and abuse, yet this is not looked at in the medical model.
- In the context of trauma, women have often experienced multiple forms of abuse and yet, the NICE guidelines are set for a single trauma not a series of traumatic events.
- While critiquing that BME women's experiences are not incorporated into the medical model it was also reflected that different things work for different women. For example therapy works when you find the right therapist. The issue is often that one size fits all models does not allow for active therapy where people are able to find a therapeutic space that works for them.
- It was also discussed that for some medical responses are useful and helpful: women find medication useful and some women find diagnosis useful.
- There was a discussion about how different diagnosis may illicit different responses. For example when someone presents with depression they may be asked about context and experience. However, voice hearers with a diagnosis of schizophrenia may be viewed in more medicalised terms and the response will be to stop the symptom without considering the context. Service user-led organisations like the Hearing Voices Network offer space to challenge this and consider hearing voices as part of people's response to trauma and abuse. However, access to groups is limited for people from BME communities, as such user-led spaces may not necessarily be able to attend to intersectional issues of 'race' and culture.
- It was explored that the medical model is a powerful one and psychiatry is a powerful discourse. Is there scope for people to challenge the model and ask questions?
- A worker from a refuge noted that mental health responses are not able to give women the space and time they need and specialist VAWG services fill the gap and act as a bridge to mental health services.

VAWG and Mental Health

VAWG erodes women's sense of self.

- It was discussed that VAWG erodes women's sense of self. Mental health services often focus on symptom control rather than supporting with restoring people's sense of self.
- VAWG is not a clinical category. Despite the overwhelming evidence that VAWG causes mental distress in women and is a key factor in women experiencing mental ill health it is not a core part of mental health training or the response.
- One speaker noted that clients are often referred to her with 'paranoid ideation' yet for her this is not paranoia. The threats are real for women who have escaped violence. Medical professionals try and treat the symptoms and impact of abuse rather than exploring the causes of those symptoms.

The idea of Recovery

Emphasis is still on symptom control

It was explored that for BME women recovery has to take in the intersections explored above: experiences of VAWG, experiences of racism, experiences of being labelled in the mental health context. Managing mental distress was about finding spaces of safety within those intersecting experiences.

Some key points about recovery are summarised below:

- Jayasree Kalathil summarised the key findings from her research with African, African Caribbean and south Asian women about what helps
    - There is a need to talk about pre-stories. Recovery cannot happen until the context of and meaning given to mental distress are understood.
    - Gaining a sense of self and identities
    - Access to healing systems and alternative therapies
    - Access to green spaces
    - Creative activities like art and writing
    - A sense of social justice and community development – this is crucial. Recovery must be moved away from the individual to consider the social context in which mental distress happens.
- The notion of recovery was unpicked and questioned, particularly in relation to the idea of recovery as being a means to get back to work. The history of psychiatry was explored and the past use of 'work-cure' being highly gendered in that it was aimed at men. In contrast women were told not to engage in the world – the book 'the Yellow Wallpaper' was discussed, a nineteenth century text in which a woman suffering from what might now be diagnosed as post-partum depression was told to disengage from the world and not read or write. It was explored that the push to get people into work today is problematic – many people want to work but what options in the work available are there for people to have a sense of self.

- Research by LBWP found that women want holistic services where they feel safe, that represent heterogeneity of experience and are flexible in their delivery model.
- Intersectional responses must be holistic and recognise the complexity of women's experiences and identities: race, class, poverty, disability, age and sexual orientation.

Responding to BME women's mental distress

- Some services are based on a model of getting people into work. This can be very disempowering for women. We must make the distinction between employment and engagement people want – people do want to feel a sense of fulfilment and selfhood. However, work for the sake of it is problematic.
- Some women find diagnosis useful and some find medication useful. Skill yourself up in understanding where a woman is at by asking questions about her experiences of those things.
- Support women to understand the medical model and health offer so they can make an informed decision. Support women to question the offers of help they receive.
- There are alternative models to the mental health system for example – there are Hearing Voices networks around the UK.
- When services explore options for support with mental distress it is useful to look at medical services but also at other local groups. A short list is provided at the end of the document.
- A good model of response to BME women is a transcultural response – for many women mental distress is a response to the things they face, for BME women in particular the intersection of gender-based violence and racism impacts on their mental well-being – this must be acknowledged in responses to them.

Summary of morning session

Overall discussion explored how BME women who had experienced VAWG and presented with signs of mental distress were not understood in those terms but were often categorised by their health symptoms. This was described as disempowering and alienating for women who had faced control and abuse in their personal lives. Crucially it was felt that women's intersecting experiences were not being heard and thus the systems meant to help them with mental distress could act be traumatising. However, pockets of good practice were acknowledged – particularly how specialist BME VAWG support services and the third sector were able to create spaces of support for women.

Barriers and Solutions

Barriers:

Based on conversation and feedback a number of barriers to supporting BME women around VAWG and mental distress were identified. These are summarised below

1. The biggest barrier identified by all people in the room was language. For women for whom English is not their first language using an interpreter can be highly problematic, particularly in a therapy setting where a third person is introduced – this can impact on the relationship between the therapist and the woman and interpreters bring their own experience to the room thus shifting the dynamic. Language barriers were also shown to be difficult in emergency situations where action may needed to be taken quickly. There was a concern about reliability of interpreters and not being certain of accuracy in interpretation. There was also a concern about mental health meaning different things to different women and so the words being used to describe mental distress being inconsistent. Finally it was identified that English may be associated with a language of imperialism and oppression and as such have implications for power dynamics.
2. Time was identified as a key issue. Waiting lists for therapy and counselling were mentioned as were the time it can take to find the right service.
3. Many felt confused about how to identify the right people and uncertainty about how to access mental health services.
4. Monitoring and evaluation was seen to take up time in offering the holistic support women call for.
5. Prejudice, racism and expectations that BME women will be a certain way
6. Inadequate funding and resources – the problem of short term funding and the impact on women.
7. A lack of safe spaces and services for BME women.
8. Pathways to support and outreach – do we know where to refer women?
9. High thresholds / criteria to access.
10. The complexity that women face in funding services that fit their needs.

Solutions:

A number of ideas were put forward to help overcome the barriers:

1. Think beyond the clinical model and question the clinical model.
2. Reflect on women's existing resources – for example – many women pray in the morning and that is mindfulness but it is not viewed as that because of

racism and medical models. - 'if you take wisdom away from the method you get idiocy.'

3. Women's model of self must be put into our approach.
4. Training for NHS, funders and commissioners.
5. Language: Increasing training for women who have languages as therapists and counsellors. Specialist interpreters that can put experience into their practice – this could be a way to tackle issue of employment for survivors as well as supporting other survivors adequately.
6. Peer support within the mental health system.
7. Interpreters that can put into practice their own experiences.
8. Thinking about the roots of health presentations – move away from thinking of symptoms of mental ill health and towards understanding signs of mental distress
9. Re-politicising mental health – which is situated within white supremacy, patriarchy and capitalism – mental health services are political and we need to raise awareness of that. Women are part of a wider structure of experience.
10. We must be critical of language – diversity is depoliticised and services just tick boxes. Identities must be politicised.
11. Reflective practice is vital – this allows people to think much more broadly about people's experiences – this underpins holistic support.
12. Safeguard specialist services that offer safe spaces led by women, offer spaces for women to be listened to and have agency, have an intersectional approach.
13. Make links between VAWG organisations and those working within the sector and the mental health user/survivor movement, thus bringing in expertise and experiences at the intersections together. This too could help create BME user-led networks within mental health.

Current Good practice

Participants were asked to identify current good practice within their own services or services they have encountered.

- Tailoring support to client's needs – it might not be a safe time for counselling.
- Strategies are survivor led.
- Client voice heard.
- Collaborative work – in both teams or with partners.
- Open door policy in refuges – it should not be us and them in services.
- Reflective practice.
- Creativity in healing and recovery – exploring the larger picture – effective use of language – thinking more broadly about what it means to empower people – workshops and newsletters for service users.
- Support for children.
- Coffee mornings.

- Case supervision and line management – making decisions as part of a team.
- Knowledge is based on users experience but also evidence base e.g. WGN use neuro-science of trauma and link it into their 30 years of knowledge and training from frontline practice.
- Strategies to overcome barriers – eg. counselling service at LAWA was combined with a crèche.
- Clinical group supervision – really helps with well-being and reflection on work and create safe spaces at work.
- EACH counselling recruit staff who speak different languages and ensure that the team have a range of different perspectives to ensure they can meet the needs of their clients.
- Networking support for BME staff.

Good practice examples

Women and Girls Network - IPAMO

IPAMO House of Healing is a multi-lingual para counselling, advocacy and interpreting training programme for women passionate about supporting women who have experienced gendered violence. The programme trains women from refugee and BME communities who are multi-lingual. The idea is to ensure that women are able to support other women and to give women opportunities to access training and gain new skills. The programme not only expands the network of support for BME women but has also allows women who receive training to find their own sense of self through supporting others.

London Black Women's Project (LBWP)

The LBWP provides therapy and counselling for domestic and sexual violence, forced marriage and FGM. They take referrals directly through IAPT and are able to offer specialist support. This is built on years of research with and support for BME women. Their model places women and girls agency at the heart of their work. They link empowerment to envisioning, supporting women to consider a world free from violence and exploring what women's interactions would be like in that world. They use storytelling and art to help women work through their experience. The focus is on a recovery of voice, self and sense of control. They've found that nature is coming out a lot in how women describe themselves and view themselves, particularly the sun as a powerful and positive force. They have also found that the theme of the interconnected self has emerged and that women often use collage to show the multiple experiences of their lives. The model is holistic – based in nature and society. There is a strong focus on equality and removing unequal power.

Next Steps?

At the end of the day participants and speakers were asked to put forward ideas for how their services could improve responses to BME women facing mental distress and what goals and values would underpin this. Speakers were then asked to put forward some thoughts or ideas about what could be done to fulfil some of the ideas put forward during the day.

Ideas for improving service responses

Training/Reflective practice on:

- Intersectionality
- Managing power dynamics.

Support for women:

- Mental health risk assessment – averse vs potential
- Peer support.

For Staff

- External supervision, individual and group – ideally clinical
- Support and supervision
- Language specific support
- Opportunities for being critical of organisations values
- Day for self-reflection
- User involvement in evaluating and designing organizational policies and culture
- Reflecting on power dynamics
- Make managers available.

Recruitment:

- Staff represent the women that they are seeing at all levels.

Partnership work:

- Build relationships with partner organisations to improve referrals
- Clarify referral systems
- Work together with other orgs to share expertise (knowledge and experience).

Goals and values

- Better understanding of mental health in BME community in VAWG context
- Considering mental health as environmental rather than a diagnosis

- The political impact – to consider how we get these messages to decision makers
- User involvement in organisational development and co-production
- Review mental health policies
- Value: shared power.

Closing thoughts

- Creative ways of evaluating services – go to local authorities and explore with them how to measure success.
- Think of ways that we can speak in the language of funders.
- How to stop BME staff being expected to represent the BME people. Consider processes of racialisation. The oppressed person should not be the ones to sort out the oppression.
- Jayasree Kalathil – the whole day has been on models. We need to connect user-survivor knowledge with professionals. Within the user survivor network – BME survivors exist in a liminal space, they work with mental health movement and experience racism, within the anti-racism movement we experience saneism. It would be nice to connect up and rethink things. Professionals view people in terms of risks but in the decisions people make the risks are the seeds of potential e.g a woman on high medication wanting a child, supporting her to have the child may be the way to move her away from medication. How can you get your service users to shape things from the start? We need to interconnect experiences and skills
- Look at the person and the journey they have not the labels they come with. Don't fit the client's needs into the model – make the models adapt to the client.
- Challenge the people you work with. Take some of this learning on and take it back to practice.
- A BME space is a safe space. How can we challenge the things that are separating these organisations and work together to keep this going and who is missing?
- We must take time to say no and look after ourselves. We must centre ourselves in our work.
- Build good partnerships to allow them to hold work that you can't.
- Talk to people in your organisation about intersectionality and gender-based violence.
- Understand your own privileges.

Useful Contacts

- Asha projects - South Asian organisation that works to end violence against women and girls. Provide advice and refuge accommodation.
- London Black Women's Project – A London based women-only black feminist organisation working to end violence against women and girls. Services include: emergency accommodation and housing support services, counselling, service for young women and girls including support groups, and legal advice and information, capacity building training to professionals, research and policy development.
- IKWRO – support and protect Middle Eastern and Afghan women and girls who are at risk of 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic violence and to promote their rights. Services include refuge, counselling, advice and training.
- Women and Girls Network (WGN) - Free, women-only service that supports women in London who have experienced violence, or are at risk of violence. Offer counselling, advocacy and advice
- National Survivor User Network – NSUN network for mental health is an independent, service-user-led charity that connects people with experience of mental health issues to give us a stronger voice in shaping policy and services.
- Hearing voices network - offer information, support and understanding to people who hear voices and those who support them.
- Sound minds - user led charity and social enterprise transforming the lives of people experiencing mental ill health through participation in arts activities
- Cane rows – was founded by mental health service users from Sound Minds with the aim of improving mental health care, particularly for people from BME backgrounds.
- Kindred minds – user-led project for people from Black and Minority Ethnic (BME) communities living in and around the borough of Southwark. Open to survivors of mental distress from BME communities.

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