# Creating Safety: Intersection Of Healthcare And Police Response to Violence Against Immigrant South Asian Women in British Columbia: A Service Provision Model

*Submitted by*

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## Copyright notice

# Abstract

## Background

Intimate Partner Violence (IPV), is an internationally prevalent health and safety issue impacting women. Immigrant South Asian women (ISAW) in British Columbia (BC) remain vulnerable to serious injuries and homicides despite efforts of healthcare and police services. It is critical to improve these responses. Knowledge of the challenges to responses can inform and improve services and the well-being of ISAW.

## Aims

This study aimed to explore the needs of ISAW and the challenges of healthcare and police responses, how these may inform responses and to compare the perspectives of survivors, responders and experts to improve the health and safety of ISAW.

## Methods

Design: a two-phased, mixed methods study. Phase 1: a purposive sample of 4 focus groups of 22 ISAW survivors from four cities in BC. An additional focus group involved five subject matter experts. Also conducted were seven face-to-face semi-structured interviews with twelve key informants. Phase 2: a convenience sample of 128 provincial responders completed an online survey.

## Results

The key emerging themes for survivors were the difficulties in identifying and disclosing IPV and the responses to IPV. Responders identified the gaps in services, culturally and linguistically inappropriate policies and uncoordinated and non-collaborative efforts. For the ISAW, perceptions, fears, and socio-cultural impediments hindered their disclosure of IPV. They required culturally and linguistically trauma informed responses, policies and practices to overcome multiple and complex challenges. Co-ordinated, collaborative systemic responses to improve the health and safety of ISAW were identified by all participants, including appropriate risk assessment.

## Conclusion

This study adds to current knowledge by contributing to the understanding of IPV of ISAW from different perspectives: ISAW survivors, responders and experts. This knowledge offers potential improvements to services and policy developments to reduce the health and safety risks to IPV survivors.

## Declaration

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This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Print Name: Harjit Kaur

Date: April 24, 2020

## Dedication

I dedicate this thesis to Akal Purkh, the Almighty for His Blessings, perseverance and spiritual guidance. My humble and sincere appreciation for Guruji's Grace and the strength and perseverance to complete this work in the spirit of informing change and contributing to the service of humanity.

I dedicate this thesis to my parents, late Sardar Lashkar Singh and Sardarni Charan Kaur for your unconditional love, faith in my abilities, your spiritual guidance, values and beliefs of kindness and generosity of sharing. My family and extended relationships for always being there for me. In particular, my sincere gratitude to late Saminder Kaur, Sarbjit Kaur, Sukhjit Kaur, Manjit Kaur, Santokh Singh, Charanjit Singh, Kamaljit Singh, Harpal Singh, Simranjit Singh and Guramrit Singh.

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## Table of Contents

## List of Tables

## List of Figures

## List of Abbreviations

| | |
|---|---|
| BC | British Columbia |
| CALTIA | Culturally and Linguistically Trauma Informed Approach |
| COVID-19 | Coronavirus disease |
| DV | Domestic Violence |
| DVRF | Domestic Violence Risk Factors |
| IPV | Intimate Partner Violence |
| ISAW | Immigrant South Asian Women |
| ISAWRAT | Immigrant South Asian Women Risk Assessment Tool |
| MCFD | Ministry of Child and Family Development |
| MPSSG | Ministry of Public Safety and Solicitor General of BC |
| MUHREC | Monash Human Research Ethics Committee |
| PODV | Provincial Office of Domestic Violence |
| RCMP | Royal Colombian Mounted Police in BC |
| VAW | Violence Against Women |
| VAWIR Policy | Violence Against Women in Relationships Policy |
| VAWIR | Violence Against Women in Relationships |

# Glossary

## Victim Services & Violence Against Women Programs in BC

These programs provide assistance to victims of crime and women and children impacted by violence and are funded by the Ministry of Public Safety and Solicitor General (MPSSG). They are defined by MPSSG as follows:

- **Community-based victim assistance programs** assist victims of family and sexual violence across BC. In some communities there are programs for women, children, youth, male survivors of sexual abuse, Aboriginal people and people from specific ethnic communities.

  ***It is important to note that Community-based victim service programs are available whether or not a woman has reported the crime to police.***
- **Stopping the Violence Counselling programs** provide individual and/or group counselling for women seeking services for childhood abuse, sexual assault and violence in their relationships.
- **PEACE (Prevention, Education, Advocacy, Counselling and Empowerment)** programs (formerly referred to as Children Who Witness Abuse programs) provide group and individual counselling for children ages 3 – 18 who have witnessed abuse, threats or violence in the home
- **Outreach Services programs** provide women with supportive counselling, information and referrals, and accompaniment and transportation to other services.
- **Multicultural Outreach Services programs** provide assistance to immigrant and visible minority women in their own language.
- **Police-Based Victim Service programs** provide services to victims of all crimes. Victims of all types of crime and trauma are assisted by police-based victim services programs located in Royal Columbian Mounted Police (RCMP) detachments and municipal police departments throughout B.C.

  *Victims of family and sexual violence are then referred to a local community-based victim service program (if there is one) for further support and assistance.*
- **Court Support Programs** provide information and support to victims of all types of crime involved in a criminal court process.

## Sexual Assault Nurse Examiner (SANE)

A sexual assault nurse examiner is a staff trained to provide health care for survivors of sexual assault. The nurse works in partnership with community-based sexual assault centre staff, police, and emergency department staff. The SANEs are available at different health authorities across BC.

## Transition Houses, Safe Homes, and Second Stage Housing

BC Housing funds the housing for women impacted by violence and supports the following programs across BC:

- Transition houses provide safe, temporary 24/7 staffed shelter with support services.
- Safe homes provide safe, temporary short term shelter and support services.
- Second-stage houses help women who have left abusive relationships make plans for independent living. Women and their children usually stay in a second-stage house for 6-18 months.

# Chapter 1. Introduction and Background

## 1.0. Introduction

This research study examines the intersection of healthcare and policing responses to violence against immigrant South Asian women (ISAW) in intimate partner relationships (IPV) in British Columbia (BC). It has the potential to improve understanding of healthcare, police and community social services for ISAW experiencing IPV. British Columbia has progressive policies and services to address the safety of immigrant women and yet there remains a need to further examine the gaps and identify safety issues for vulnerable ISAW who continue to suffer from injuries and, in some cases, homicides. An examination of the intersection of the healthcare and policing response system will provide important information for BC to increase the safety of women accessing critical healthcare and police response systems.

## 1.1. Background

Violence against women remains a world-wide reality and presents an ongoing concern. In BC, healthcare and criminal justice-related provincial and community-based initiatives and policies continue to make attempts to address IPV experienced by women. Violence against women affects an estimated one third of women across the world from all socio-economic, religious and diverse communities (WHO, 2013). In the literature, violence against women is also referred to as IPV, domestic violence, family violence, spousal assault and violence in relationship. IPV is the use of coercive and controlling behaviour by a partner to threaten and instigate fear in order to maintain power and control; violent or non-violent acts may include financial, emotional, spiritual, physical, sexual violence and abuse or isolation, though such acts are not limited to these factors alone and may be a compilation of a variety of factors (Dawson, Sutton, Carrigan & Grandmaison, 2018; Jordan & Bhandari, 2016). Using this term reflects the gendered nature of violence against women. IPV exists across genders, though women make up the majority of the survivors.

In Canada, over the past four decades, a woman or girl is killed by violence every two and a half days (Burczycka, 2018; Dawson et al., 2018). In 2018, 79% of the intimate partner homicide victims were women (Burczycka, 2018). Physical injuries due to IPV were sustained by 56% of the victims and six in ten IPV homicides between 2008 and 2018 had a known history of family violence (Burczycka, 2018). Survivors come in contact with healthcare services as a result of injury and health issues, yet only a small number of women disclose IPV to a healthcare practitioner. Several factors influence the increased vulnerability of immigrant women and whether they report, disclose or seek help for IPV. These factors include the cultural and social norms, level of education, financial considerations, years in the country, immigration status, fear of deportation, religious affiliation and expectations, history of abuse and witnessing abuse, linguistic skills, and knowledge of services and supports in the community (Jiwani & D'Aoust, 2001; Sabri, Nnawulezi, Njie-Carr, Messing, Ward-Lasher, Alvarez, & Campbell, 2018).

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 as a pandemic, while stressing that IPV continues to prevail as a serious global public health concern as IPV threats to women's'

health and safety during such emergencies exponentially increases (WHO, 2020). Public health issues, including pandemics such as COVID-19, increases the incidence of IPV and anxiety for women across the world, with some countries already reporting IPV increases of approximately 25% (United Nations, 2020). Additionally, the restriction to travel and self-isolation due to COVID-19 lockdowns increases the incidences of IPV and Amy FitzGerald, Executive Director of the BC Society for Transition Houses sums this up as "a public health and safety crisis and emergency. Not only in Vancouver and Canada, but in North America and the world. It is an epidemic all by itself" (Steacy, 2020). The increase in IPV incidences and the complexity of help-seeking for women is further affected by the reduced availability of support services, including healthcare and police responders, which are already being overused, repurposed or unavailable to women (UN, 2020). Hence, it is important to note that serious social change plays a significant role in increasing the incidence of IPV for all women.

### 1.1.1. Defining violence against women

Violence against women has been referred to using various names by researchers and anti-violence community services to capture the violence inflicted against women in intimate relationships. Violence against women reflects the gendered nature of the violence and helps in understanding the scope of the issue (Rossiter, 2011). The literature refers to the issue by interchangeable terms, including; family violence, domestic violence, spousal assault, spousal abuse, intimate partner violence, wife assault, wife abuse, gender-based violence, violence in relationships and battered women. The words *abuse* and *assault* have also been used. Hence, there is a complexity associated with using multiple combinations of the above in order to understand the issue of violence against women in relationships by their spouses. On the contrary, the BC's Provincial Violence Against Women in Relationships (VAWIR) policy is consistent with the United Nations Declaration that acknowledges the violence as gender-based and a crime of power and control (Brennan, 2012).

The unified and consensual definitions and behaviours describing IPV perpetrated by men resulted in the naming of IPV in 1999 by the U.S. Centre for Disease Control (CDC), and the resulting development of typologies of IPV by the U.S. Centre for Disease Control and the World Health Organization (Mason & Hyman, 2008). These areas encompass: physical or sexual violence, emotional violence, psychological violence, and threats, deprivation or neglect, leading to a more inclusive definition of IPV.

There remains an ongoing usage of different terms to refer to the situations of violence against women in intimate relationships (Ending Violence Association of BC (EVA BC), MOSAIC, & Vancouver and Lower Mainland Multicultural Family Support Services, 2010; Light, 2007). Researchers and policy makers use a range of terms and select them based on what they choose to reflect with them. Feminists have referred to the situation as violence against women – framing the term to reflect the gendered nature of the violence and choosing to locate the term within the bigger framework of economic and financial disparities, as well as the social positioning of women within the global situation of women based on the inequalities they continue to face. The United Nations concurs with this location and selection of term to describe the global

situation (Jiwani & D'Aoust, 2001; Light, 2007; Smith, 1987). Scholars and feminists continue to articulate that these situations have to be understood within the 'power and control' situations faced by women in patriarchal societies (Jiwani et al., 2001; Shirwadkar, 2004). The term fits well with the positioning of ISAW as the Indian sub-continent remains deeply entrenched in the patriarchal system that permeates the lives of women long after they migrate to countries such as Canada.

The other term that is used commonly and by the Province of British Columbia, is domestic violence. This is reflected in the policies and frameworks used by the Provincial Office of Domestic Violence. This term contradicts the term used by the Ministry of Attorney General and public safety office where violence against women guides the VAWIR policy (Violence Against Women in Intimate Relationships) and is used by the police. In healthcare, the term IPV has been most commonly used in the literature. Hence, this study will use IPV to refer to this widespread issue of violence against women. An important consideration in the definition of IPV through cultural interpretation needs to reflect upon the varying meanings of IPV across cultures and within cultures (Krauss, 2006; Hyman, Mason, Guruge, Berman & Kanagaratnam, 2011). These multiple lenses across different countries and culturally-specific populations results in discrepancies and confusions regarding its definition by immigrant women experiencing IPV (Latta & Goodman, 2005; Raj & Silverman, 2002).

### 1.1.2. Violence against immigrant women

British Columbia (BC) has progressive policies and services to address the safety of immigrant women, however, more needs to be done to reduce the vulnerabilities faced by ISAW who continue to suffer from injuries and homicides. According to Statistics Canada (2016), the population of visible minority females in Canada has been increasing since 1981. In 2011, South Asian females made up the largest group of visible minority females at 61% (Hudon, 2016) and is projected to increase to 31% in 2031. Therefore, in order to ensure that the healthcare and safety nets do not fail ISAW experiencing IPV, it is important that an effective and accessible service delivery system is in place.

The existing social and cultural influences remain strong among ISAW, requiring an understanding in order to affect the development and implementation of appropriate systems of support and policies to address the issue of IPV in the community. The pre-migration experience of immigrant South Asian women influences help-seeking behaviours of women everywhere (Sabri et al., 2018). These experiences are coloured by the strong Indian patriarchal system, preference for sons, the dowry system, arranged marriages, forced marriages, child marriages, and the migration process (Anitha, 2011; Jordan et al., 2016; Kallivayalil, 2010). These experiences result in further isolation, lack of support and knowledge of local resources and laws, financial and psychological stress, the sacrament of marriage, marital rape (not a crime in India), and the negative attitudes associated with separated or divorced women, all of which influences attitudes and social underpinnings of IPV and social positioning in society (Light, Ruebsaat, Turner, Novakowski & Walsh, 2008).

ISAW experiencing abuse in BC do not adequately access the available healthcare services and police protection. It is important to understand the needs of ISAW and their interactions with the healthcare and police response system in BC. Research cites immigrant women risk violence in their lives, and live with the fear of deportation with the involvement of the police (Shirwadkar, 2004). In particular, it calls for a closer look at the formal healthcare and police protection services and policies impacting women affected by IPV in relationships.

Women who may be vulnerable due to recent migration and acculturation, language, social and cultural barriers, are often restricted from seeking access to healthcare and the criminal justice system due to internal and external factors from other ethnic backgrounds (Du Mont, & Forte, 2012; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit & Brotman, 2010). Addressing the gaps/problems/barriers facing ISAW can improve and increase their safety. The low reporting rates of IPV, continuing injuries and homicides of ISAW raise questions regarding the resources dedicated to IPV identification, education and support for self-disclosures within healthcare and police services for ISAW. Previous health care, political, social and cultural experiences of ISAW migrating to Canada from the Indian subcontinent influence women's decisions to disclose or reach out for support services. This study provides an understanding of how healthcare and police services can improve their response to IPV experienced by ISAW.

On a provincial level, a series of tragedies involving deaths or injury of immigrant women in BC has highlighted the need to ensure that service providers from all relevant sectors are able to identify domestic violence (DV) risk factors and make appropriate referrals for women and children who are at risk (EVA BC et al., 2010). In fact, immigrant women in general who are experiencing IPV will not disclose it without support and encouragement of formal and informal supports, while also reporting that they were not treated fairly by healthcare and other service providers (Bhandari, 2018; Du Mont et al., 2012; Sabri et al., 2018). The Canadian data indicates that the rate of police-reported IPV dropped 12% between 2009 and 2018 (Burczycka, 2018). A smaller number of women disclose abuse to physicians when seeking medical attention resulting from domestic abuse (Feder, Hutson, Ramsay, & Taket, 2006; Jiwani et al., 2001; Sabri et al., 2018). Healthcare workers, police and community social service workers may be the first point of contact for many immigrant women experiencing abuse. As such, it is critical that healthcare and police response services be equipped with knowledge of IPV, lethality risks, managing disclosures and effectively addressing safety issues relating to ISAW (Jiwani et al., 2001; Sabri et al., 2018).

### 1.1.3. Concept of Safety

Another definition that requires an understanding is the concept of safety as understood by women in these situations. The concept of safety and safety planning continues to be defined as feminist researchers and scholars continue work in this area, while the ability to safety plan provides women with a sense of confidence (Jeffrey, Fairbairn, Campbell, Dawson, Jaffe, & Straatman, 2018; Kulkarni, Bell & Rhodes, 2012).

### 1.1.4. Cultural Safety

Cultural expectations and social norms play a critical role for ISAW. Yet, this understanding has not been researched thoroughly. One gap that remains is an accurate measure of the prevalence of abuse within immigrant communities in general. Researchers have not collected such data for reasons that could further stereotype and stigmatise immigrant communities as more violent, generating negative views about males in the community (Thandi & Lloyd, 2011; WHO, 2013). Enhancing the safety of ISAW requires an understanding of her needs, socio-cultural realities and knowledge and access to community resources (Davies, Lyon & Monti-Catania, 1998; Jeffrey et al., 2018; Sabri et al., 2018). It is essential for healthcare practitioners to ask about physical or sexual violence as well as emotional and other signs of IPV to facilitate timely identification of health and safety risks, which can be of particular significance for ISAW with due consideration of delayed IPV disclosures (Ahmad, Driver, McNally, Stewart, 2009; Ahmad, Smylie, Omand, Cyriac, & O'Campo, 2017).

### 1.1.5. Violence Prevalence: BC Statistics

In BC, healthcare and criminal justice-related provincial and community-based initiatives and policies continue to make attempts to address IPV. In 2009, immigrant communities made up 25% of the overall BC population. Yet, in the preceding 15 years, immigrant women accounted for up to 40% of the domestic violence deaths (EVA BC et al., 2010). An immigrant in Canada is someone who is, or has, ever been a landed immigrant or permanent of Canada and it includes persons who are granted Canadian citizenship by naturalisation (Statistics Canada, 2018).

According to police data of family violence incidence in 2018 (Burczycka, 2019):

- Almost 30% of victims of police-reported IPV were victimised by an intimate partner
- Females accounted for 79% of IPV victims
- Most IPV (84%) occurred at home
- Women continued to be at a higher risk of IPV homicide between 2008 and 2018 (79%)
- 73% of females were killed by a current or former legally married or common-law husband

### 1.1.6. Types of Violence against Women

According to the 1993 General Assembly of the United Nations, 'Declaration on the Elimination of Violence Against Women', violence against women refers to "any act of violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women including threats of such acts, or coercion or arbitrary deprivation of liberty, whether occurring in the public or private life."[1]

An elaboration of violence against women includes, without limiting it to, acts that consist of the following types of behaviours and actions:

[1] United Nations. Declaration on the Elimination of Violence Against Women. Dec 20, 1993. https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/48/104

**Physical:** the utilisation of physical power and the enforcement of deprivations that remain detrimental to one's physical health as a result causing bodily harm.

**Emotional/psychological or verbal:** threats resulting in harm to the woman, her children and family members. It includes emotional and psychologically decretory language and actions, manipulation, blackmail and constricting her interaction with social networks.

**Financial:** control and hampering access to money or personal items.

**Spiritual:** the use of her spiritual or religious practices and beliefs to enforce control, fear, or dominance.

**Sexual:** lack of consent to engage in sex or safer sex, including the use of blackmail, fear, threats or physical force. It could include forced abortions, prostitution, pornography or other unwanted sexual acts.

**Criminal harassment/stalking:** use of tracking devices to follow and watch a woman. Sending emails, texts, calling and leaving messages to instil fear, invading privacy and safety. Using children, friends and family to inform on activities (Canandian Women's Foundation, 2016; Dawson et al., 2018).

### 1.1.7. Impact of IPV

The incidence of this pervasive world-wide reality and issue of IPV impacts women's health and well-being ranging from a spectrum of medical effects. These are documented as resulting from cumulative and recurring types of violence over a period of time (García-Moreno, Hegarty, d'Oliveira, Koziol-McLain, Colombini, & Feder, 2015; WHO, 2012, 2016). These effects can be further complicated for ISAW due to factors such as migration, cultural, patriarchal, social, financial, and spiritual (Bhandari, 2018; Jiwani, 2005; Sabri et al., 2018).

**Physical and psychological health, injury and death**

IPV results in short-term and long-terms health effects which depends and varies on the type of violence, incidence of violence and its severity ( Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006; WHO, 2013).

Research in this area indicates that the health effects include injuries to the head, face, neck, pelvic or abdominal areas in addition to fractures, contusions, cuts and abrasions (WHO, 2013). In addition, strangulation, choking, sleep and gastrointestinal disorders and abdominal and intestinal problems have been consistently recorded (Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, & Sharps, 2003; WHO, 2013). Studies indicate that women experience gynaecological problems, unsafe abortions and unwanted pregnancies, miscarriages, pelvic issues, and a range of sexual dysfunction and sexually transmitted infections. The results are also shown to affect the foetus, often resulting in pre-term births (Campbell et al., 2003; Shah & Shah, 2010).

The most prevalent psychological consequences include depression and Post-Traumatic Stress Disorder (PTSD), among others such as psychosocial and psychosomatic disorders including self-harm and suicidal ideation (WHO, 2013). Criminal victimisation and harassment often results in ongoing health-related concerns even after women end abusive relationships (Afifi, MacMillan, Cox, Asmundson, Stein & Sareen,

2009; AuCoin & Beauchamp, 2009). Women can experience another level of this impact as a result of continuing relationships with children, family relations, ties with extended family members and community links, and this is more important for ISAW.

### 1.1.8. Healthcare and Police

An estimated one third of women's health is affected globally by the prevalence of IPV (WHO, 2013). Survivors may come in contact with healthcare services as a result of injuries and/or resulting health issues. According to a multi-location study in the United States, 41% of women killed by their intimate partners were attended to by healthcare one year prior to their death (Sharps, Koziol-McLain, Campbell , McFarlane, Sachs & Xu, 2001). Police reported that 70% of women killed by their intimate partners had a history of domestic violence (Statistics Canada, 2016).

**Hospital policies**: A key question is how safe and supported ISAW feel about disclosing the abuse to healthcare practitioners when seeking medical attention. Despite the suggestions by researchers and healthcare practitioners for screening tools, according to Allard, (2013), many survivors attending emergencies go unnoticed by healthcare professionals. The study by Jiwani et al., (2001), also suggests that healthcare professionals either do not have the time to ask appropriate questions or feel that they do not have the right information to make appropriate referrals. Both of these situations result in ISAW being increasingly vulnerable to continuing abuse. More and more focus is now on the high economic, social and healthcare cost associated with domestic violence. Black (2011) suggests that the prevention and intervention of domestic violence can reduce these costs in addition to improving the health of patients.

**Risk and identification:** Researchers in IPV offer a variety of arguments for addressing the intervention or response to these issues. In the healthcare and police response systems, immigrant women are still not efficiently or effectively screened for violence and risk factors in the relationships (Light et al., 2008; Messing, Amanor-Boadu, Cavanaugh, Glass & Campbell, 2013; Sabri et al., 2018).

According to research, screening for abuse and injury within the healthcare system should be performed routinely by practitioners (Allard, 2013, Feder et al., 2006; Sabri et al, 2018; Sprague, Kaloty, Madden, Dosanjh, Mathews & Bhandari, 2013). This raises concerns for confidentiality and the safety of the woman and her children. In many cases, the possibility that the abusive partner may find out about the disclosure has the potential to increase the risk of violence. In addition, a lack of safety planning and appropriate referrals to services could further increase the risk of injury or death with an overall need to include appropriate support interventions (Campbell 2001; Messing & Campbell, 2016). As a result, ISAW face the added complexity of barriers that include but are not limited to the fear of deportation, fear of losing their children to the extended families or their spouses, the interaction with the justice and police systems, situations of dual arrests (where the victim of the abuse is arrested as well as the abusive spouse), language barriers, social and community isolation, economic and financial consequences among others (Light et al., 2008; Provincial Office of Domestic Violence (PODV), 2012).

## 1.2. Aim of the study

The aim of this study was to examine and understand the needs of ISAW in BC Canada, experiencing IPV and interacting with healthcare and police services.

## 1.3. Research questions

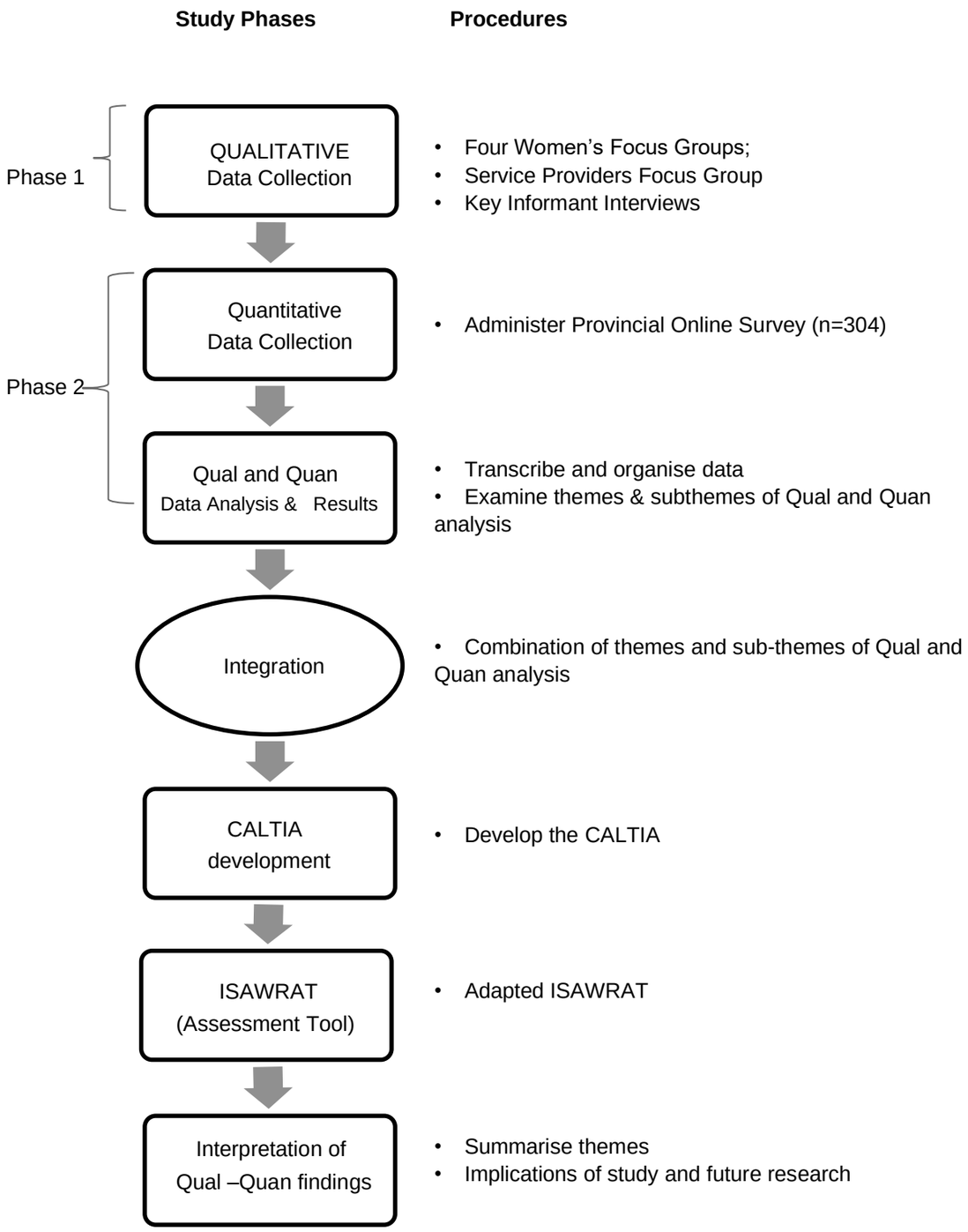
This study sought to explore three key questions:

1. What barriers do ISAW face when disclosing IPV to community social services, healthcare providers and police?
2. How do community social services, healthcare providers and police respond to IPV experienced by ISAW?
3. What interventions of community social services, healthcare providers and police can improve the safety and well-being of ISAW in BC?

## 1.4. Study Design

A modified exploratory, sequential mixed methods approach, (Creswell, 2013; Creswell, Gutmann, Hanson, & Clark, 2008) was adopted to address the research questions (see section 1.2) of the study. Phase one of the study captured qualitative data of the IPV experiences of South Asian women and the responses of senior management staff of healthcare, police and community social services in British Columbia (BC). Interviews were also conducted with key informants working in the areas of provincial and government policy and practice. Phase two, the quantitative data collection of this study, entailed the administration of the provincial online survey of frontline healthcare, police and community social service responders to understand their perceptions, challenges, practices and recommendations when responding to IPV of ISAW. Qualitative and quantitative data were integrated and interpreted in order to answer the research questions (Creswell, 2013; Creswell et al., 2008; Leech & Onwuegbuzie, 2009). The data collection permitted the comparison and contrast of the findings and identified common themes (Creswell et al., 2008).

The results of the study were instrumental in informing the gaps and challenges faced by ISAW, while providing insight into current practices and recommendations for improvements in service delivery of healthcare and police services. The exploration of the qualitative and quantitative findings were combined to develop the Culturally and Linguistically Trauma informed Approach (CALTIA). In addition, the findings can inform the adaption and development of the Immigrant South Asian Women Risk Assessment Tool (ISAWRAT), to assist with the early identification of IPV among ISAW. Figure 1.1 depicts the overall research design of the two-phased modified exploratory, sequential mixed methods approach of this study.




*Notes: CALTIA – Culturally and Linguistically Trauma- Informed Approach: ISAWRAT – Immigrant South Asian Women Risk Assessment Tool; Qual – qualitative; Quan – quantitative*

**Figure 1.1: Overview of study research design**

## 1.5. Significance of the study

The findings from this study will enhance understanding of victim vulnerabilities, safety needs, the potential risks, service delivery, safety planning and training issues for frontline communities, healthcare and police service responders for this group of women for the first time. Findings are also expected to provide information regarding the barriers and challenges within the system, service responses, and government policies. In addition, the study provides insight to the examples of successful supports and situations when ISAW were able to leave relationships safely. The understanding of healthcare and police intervention that

have worked well remain fundamental to achieving consistency and improvement in the service delivery in IPV situations.

The focus on partnership with community workers, involving survivors from community agencies and the engagement of service providers and stakeholders working in the field, could enrich the research findings by translating them into appropriate service delivery policies and programs that the participants themselves could benefit from (Hankivsky et al., 2010; Morrow, Hankivsky, & Varcoe, 2007). The involvement of community workers and stakeholders in this study will guide the process to keep it accountable, relevant, and representative, appropriate and current, grounding the analyses in the lived experiences of the women (Hankivsky et al., 2010).

## 1.6. Chapter Summary and organisation of the thesis

This chapter introduced the statistical information regarding IPV in Canada, the nature of IPV and its consequences, as well as the service provision for women experiencing IPV. It provided an overview of the critical and urgent need to address the continuing impact of IPV of ISAW in BC and the global existence of IPV. The incidence of injuries and lethality risks to the lives of women and children calls for further understanding to address the gaps to healthcare and police help in situations of IPV. It provides the background and importance of conducting this study.

Chapter 2 provides a literature review of the experiences of IPV of ISAW and the healthcare and police response. A scoping review was conducted to understand the research that has been undertaken in the literature pertaining to the experiences of ISAW.

Chapter 3 is a discussion of the study's research design, philosophy and its approach. It outlines the study's recruitment process and the associated ethical and safety considerations relating to the participation of ISAW survivors of IPV, sampling, analysis and interpretation of the data.

Chapters 4 presents Phase one of the qualitative results of the four women's focus groups. It encompasses the demographic information and findings as a descriptive account of the women's voices gathered through the focus groups and a summary of the data collection process and data analyses. The study's Phase one qualitative results were divided into the experiences of the ISAW group (Chapter 4) and the experiences of service providers (healthcare and police services) for ISAW and experts from the policy and management areas (Chapter 5).

Chapter 5 reports the results of both the service providers' focus group and the key informant interviews conducted with the policy makers, policy analysts and management professionals. The findings of this chapter are integrated to provide a more comprehensive picture of the service delivery and response of healthcare and police to IPV of ISAW.

Chapter 6 details the findings of Phase two, the quantitative data. It reports the results of the online survey of frontline responders and provides a descriptive analysis of the quantitative findings relating to ISAW experiencing IPV, accessing healthcare and police services.

Chapter 7 is a discussion of the integrated findings of both the qualitative and quantitative results. The in-depth exploration of experiences of the ISAW, the challenges they faced and the identification of strategies to improve the healthcare and police service delivery, policies and practices informs the discussion in this chapter. The findings informed the development of the Immigrant South Asian Women Risk Assessment Tool (ISAWRAT), to assist with the early identification of IPV among ISAW.

Chapter 8 presents the conclusion of the thesis. It discusses its addition to existing knowledge resulting from the integration of the Phase one and Phase two of the study. The implications of the study are highlighted with recommendations for future research to improve the health and safety of ISAW.

# Chapter 2. Literature Review

## 2.1. Introduction

Chapter 2 presents a review of the existing literature based on the experiences of immigrant South Asian women (ISAW) and intimate partner violence (IPV), and the services they receive from healthcare and police responders to remain healthy and safe. The literature reviewed includes studies about the IPV experiences, challenges and interventions that work when interacting with healthcare and police services in different countries including Canada, United States of America, UK, Australia and Asia.

## 2.2. Aim of literature review

The aim of this review was two-fold: first, to obtain information about the experiences of ISAW with healthcare and police services for the purpose of increasing their health and safety to effectively and efficiently prevent and intervene in situations of IPV. Second, to understand how healthcare and police response can improve health and increase the safety of ISAW experiencing IPV in BC. This review will contribute to understanding the unique experiences relevant to ISAW experiencing IPV.

## 2.3. Search strategy

The CINAHL, Scopus, OVID, PSYCHOINFO, MEDLINE and google scholar databases were utilised to search for research papers and/or scholarly papers and grey literature. Keywords used in the search included: abuse; assault; battered women; healthcare response; domestic violence; immigrants; women; ipv (intimate partner violence); police response; and South Asian. The inclusion criteria is depicted in Table 2.1. Articles that were not peer-reviewed, without an abstract, in languages other than English, included males, children and youth under the age of 18, or published after 2019 were excluded. Yet, in some instances additional literature has been included to substantiate arguments and discussions in this review.

**Table 2.1: The inclusion criteria**

| |
|---|
| Peer reviewed |
| Published between 2008-2019<br><br>The period 2008 to 2019 was selected as it provides just over a decade of research done in this area. Earlier research is referenced in this review to provide a broader perspective of the issue. |
| Available in English |
| Abstract available |
| Related to South Asian adult women (age 18 years and older).<br><br>South Asian is used to reference individuals belonging to the ethnic groups originating from countries including India, Pakistan, Bangladesh, Sri Lanka, Bhutan, and Nepal. In Canada, the terms East Indians or Indo-Canadians has also been used interchangeably for South Asians. |
| Address the experiences of ISAW with healthcare and police to prevent and intervene in situations of IPV |
| Understand how healthcare and police response can improve health and increase the safety of ISAW |

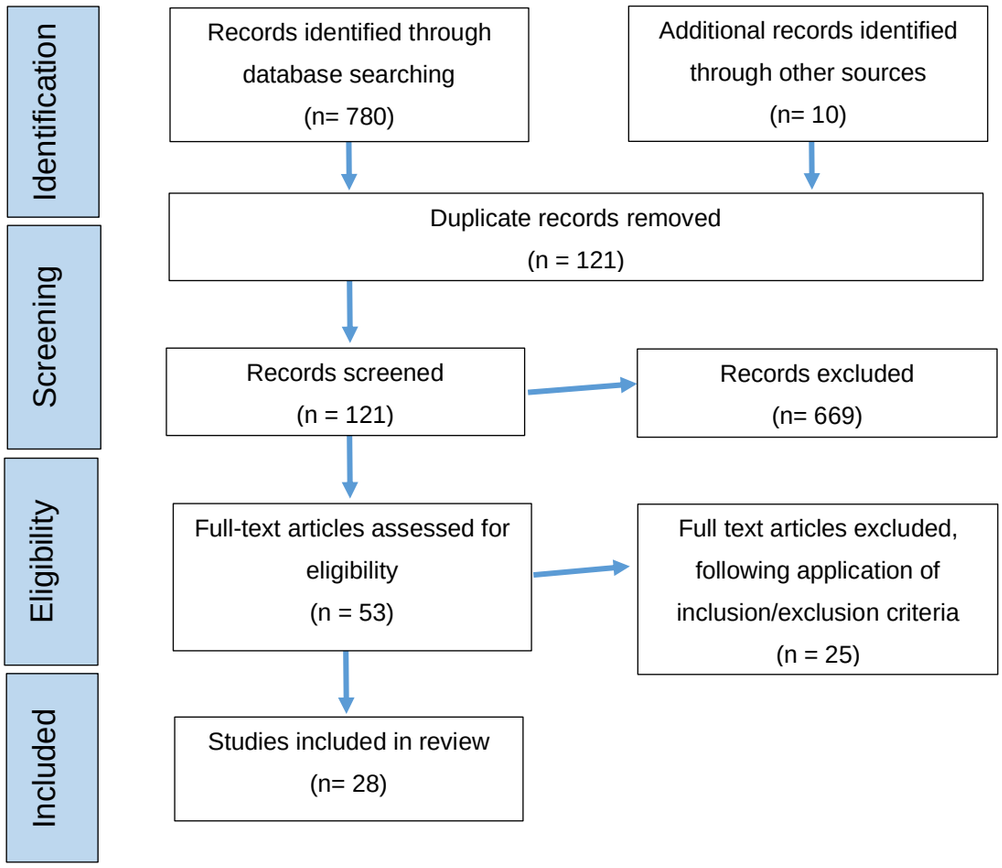



**Figure 2.1: Literature Review Flow diagram**

The search resulted in a total of 790 articles that were published between 2008 and 2019 (Figure 2.1). A majority of the studies were descriptive, employing a qualitative approach to identify IPV involving police and healthcare response. The sample, (n=28), also included risk assessment tools and interventions for both the healthcare and police services (Appendix G) but quality appraisal was not undertaken.

## 2.4. A contextual background

Violence against women is a world-wide reality and presents an ongoing concern. According to the United Nations, violence against women refers to "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women including threats of such acts, or coercion or arbitrary deprivation of liberty, whether occurring in the public or private life." (United Nations Declaration on the Elimination of Violence against Women, 1993[2]).

IPV is a serious public health issue and, according to research, it is a pervasive issue globally including ISAW communities (Soglin, Ragavan, Immaneni & Soglin, 2019; Jeffrey et al., 2018; WHO, 2012, 2016). It is also less studied among immigrant South Asians (Ahmad et al., 2017; Hyman, Mason, Guruge, Berman, Kanagaratnam & Manuel, 2011; Raj, Silverman, McCleary-Sills, & Liu, 2005). The prevalence of IPV among women puts them at higher risk of severe injuries and homicides and, within the immigrant South Asian

[2]United Nations. Declaration on the Elimination of Violence Against Women. Dec 20, 1993. https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/48/104

communities, its quantification remains unclear and a concern regarding healthcare and police response (Burczycka & Conroy, 2017; Jeffrey et al., 2018). Outcome statistics are generally collected and accounted for, without specific reference to the ethnic affiliation of immigrant populations. In Canada, homicides of women are 4.5 times higher than men, making the focus on women imperative (Beaupre, 2015; Jeffrey et al., 2018). Literature available on any estimates of the prevalence of IPV of ISAW across North America varies widely between 21-60% (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006; Raj & Silverman, 2002, 2003; Raj et al., 2005; Soglin et al., 2019; Thapa-Oli, Dulal, & Baba, 2009; Yoshioka, Dang, Shewmangal, Vhan & Tan, 2000). Based on previous studies, IPV is alarmingly high in South Asia, including countries such as India, Pakistan, Bangladesh and Sri Lanka, encompassing homicides resulting from patriarchal cultural practices such as honour killings and demands for dowries (Ahmad et al., 2009; Johnson & Johnson, 2001; Prasad, 1999). As a result, the study of IPV among immigrants outside of South Asia is valuable.

### 2.4.1. Defining IPV

IPV, also referred to by various terms including violence against women, has been referenced by various researchers and anti-violence community services to encapsulate the violence inflicted against women in intimate relationships. Violence against women is the term utilised to reflect the gendered nature of the violence and to understand the scope of the issue (Jeffrey et al., 2018; United Nations Declaration on the Elimination of Violence against Women, 1993). The research literature refers to this issue interchangeably, including: family violence, domestic violence, spousal assault, spousal abuse, intimate partner violence, wife assault, wife abuse, gender-based violence, and violence in relationships. It is important, then, to note that there is no single term to describe the phenomenon of violence against women by their spouses.

The complexity of using multiple definitions to refer to IPV not only complicates the already serious and pervasive issue, it confounds it for both the survivors of IPV and the service providers. Researchers and policy makers use a range of terms and select them based on what they choose to reflect with them. Feminists have referred to IPV as violence against women – framing the term to reflect the gendered nature of the violence and choosing to locate the term within the bigger framework of economic and financial disparities. It also reflects the social positioning of women within the global situation of women, based on the inequalities they continue to face (Jiwani et al., 2001; Light, 2007). Scholars and feminists continue to articulate that these situations are pervasive and should be understood within the power and control situations faced by women in patriarchal societies (Jiwani, et al., 2001; Johnson, 2006; Shirwadkar, 2004). The term fits well with the positioning of immigrant South Asian women as the Indian sub-continent remains deeply entrenched in the patriarchal system that permeates the lives of women long after they migrate to western countries such as Canada. British Columbia's Provincial Violence against Women in Relationships (VAWIR) policy is consistent with the United Nations Declaration that acknowledges the violence as gender-based and a result of power and control dynamics in relationships (Brennan, 2011).

In addition to the lack of consistency of terms referring to IPV, there is a further lack of clarity surrounding the identification of IPV for ISAW and providers within both healthcare and police services. Despite attempts

by international bodies such as the World Health Organization (WHO), to provide clarity in defining IPV, there continues to be confusion among service providers particularly relating to immigrant women. According to Mason and Hyman (2008), IPV is interpreted utilising multiple lenses across different countries and culturally-specific populations. Furthermore, there is confusion regarding its definition by immigrant women experiencing IPV (Latta & Goodman, 2005; Raj & Silverman, 2002).

Unified and consensually agreed-upon definitions and behaviours describing IPV perpetrated by men, resulted in the naming of IPV in 1999 by the U.S. Centre for Disease Control (CDC) and the development of typologies of IPV by CDC and WHO (Mason & Hyman, 2008). These encompassed physical or sexual violence, emotional violence, psychological violence and threats, deprivation or neglect, leading to a more inclusive definition of IPV.

A further consideration expressed in the literature is the understanding and definition of IPV based on the cultural lens interpretation. Cultural interpretations of IPV reflects the varying meanings of IPV across and within different cultures (Krauss, 2006, Mason & Hyman, 2008). This is so evident that in different languages and cultures the single term IPV may not only be non-existent, it may not even be easily translatable (Mason & Hyman, 2008). Previous research indicates the lack of clarity in relation to the forms of abuse across cultures (Gustafson & Illuebbey 2013; Kalunta-Crumpton, 2013). Hence, there is no consistent terminology to describe the violence perpetrated by men against their spouses. Clear criteria about what constitutes IPV, and an understanding of the differing tolerance levels of acts of violence, is also lacking across communities. This is further complicated when people and communities migrate across the world. The absence of consistent terminology and differing tolerance of IPV is further subjected to different laws in their new homelands.

### 2.4.2. Impact of IPV

Violence against women results in a wide spectrum of health complications for women as a result of the lack of identification of IPV and the inability to attain the specific support and help for it. The impact of IPV on medical effects of women range from emotional to physical injuries and death. The impact is documented as a result of cumulative and recurring types of violence over a period of time. (Wathen & MacMillan, 2012; WHO, 2005, 2011). These health effects can be further complicated for immigrant South Asian women due to factors such as migration, cultural, patriarchal, social, financial, and spiritual. (Anitha, 2011; Hyman et al., 2011).

IPV causes short-term and long-term health effects which depends and varies according to the type of violence, frequency or incidence of violence and its severity (Wathen & MacMillan, 2012; WHO, 2013; Scott-Storey, 2011). Research in this area indicates that the health effects include injuries to the head, face, neck, pelvic or abdominal areas, in addition to fractures, bruises, cuts and abrasions (Sheridan & Nash, 2007; Wathen et al., 2012; WHO, 2013; Wu, Huff & Bhandari, 2010). Additionally, strangulation, choking, sleep and gastrointestinal disorders and abdominal and intestinal complications have been consistently recorded (Campbell, & Soeken, 1999; Campbell, Webster, Koziol-McLain, Block, Campbell, Curry & Sharps, 2003;

WHO, 2013). Studies of IPV also document women experiencing gynaecological problems, unsafe abortions and unwanted pregnancies, miscarriages, pelvic issues, in addition to a range of sexual dysfunction and sexually transmitted diseases. A further effect on the foetus, includes pre-term births (Campbell et al., 2003, Shah & Shah, 2010; Wathen & MacMillan, 2012; WHO, 2013).

Research identifies that immigrant women are subjected to forced marriages and honour-based crimes, often resulting in forced sexual assaults and unwanted sex. As a result women tend to be compelled to undergo multiple abortions and suffer psychological consequences including depression and Post-Traumatic Stress Disorder (PTSD), among other psychosocial and psychosomatic disorders such as self-harm and suicidal ideation (Ellsberg, Jansen, Heise, Watts & Garcia-Moreno, 2008; Jordan & Bhandari, 2016; Wathen et al., 2012; WHO, 2013). Women who leave their abusive relationships often continue to be subjected to criminal victimisation and harassment resulting in ongoing health and safety issues (Afifi, et al., 2009; Wathen et al., 2012; Wuest, Ford-Gilboe, Merritt-Gray, Varcoe, Lent, Wilk, & Campbell, 2009). In particular, immigrant South Asian women continue to experience re-victimisation as a result of continuing relationships due to their children, family relations and ties with extended family members and community links (Gill, 2004; Bhandari, 2018). According to Ahmad et al., (2009), the risk of IPV exists for all women across cultures, while a higher risk is apparent for marginalised socio-political community groups.

## 2.5. Experiences of ISAW

Socio-cultural influences remain strong among immigrant South Asian women and requires the development and implementation of appropriate systems of support and policies to address IPV in any community. Research in gender based IPV maintains the key attributes of power and control, resulting from social structures supported by patriarchal values (Messing, Becerra, Ward-Lasher & Androff, 2015). A more recent study (Sabri et al, 2018) of immigrant and refugee women, identified cultural norms such as the societal status of women, conformity to gender roles and responsibilities, and the normalising of IPV as additional factors of relevance. There is a clear disjuncture between normalising and identifying IPV as violence and as unacceptable in different countries. The literature also reveals the inconsistency that exists in the level of acceptance of IPV among different cultures (Gustafson & Illuebbey, 2013; Kalunta-Crumpton, 2013). Strong patriarchal societal values and beliefs, and family honour, prevail among American ISAW (Yoshioka et al., 2000). In fact, according to research, the existence of patriarchal beliefs and values continue to persist within the ISAW in Canada and, as a consequence, results in their inability to identify its signs (Ahmad, Riaz, Barata & Stewart, 2004). The participation of in-laws and in some cases the perpetration of abuse to ISAW by them has been documented in the literature (Hyman et al., 2011; Mehrotra, 1999; Soglin et al., 2019).

### 2.5.1. Identification of IPV

According to the early literature review conducted by Srinivasan and Ivey (1998), the non-identification of certain IPV attributes by survivors are related to socio-cultural and family roles and responsibilities. In fact, the delayed identification and recognition of IPV related risks to health and safety are heightened by their

social-cultural norms and beliefs (Hyman et al. 2011; Stith, Smith, Penn, Ward, & 2004; Tonsing 2016, Sabri et al, 2018). The considerable fear of threats of violence, increasing severity and frequency of abuse, is a fundamental and ongoing concern highlighted in the literature for both immigrant and non-immigrant IPV survivors (Campbell et al. 2003; Messing et al., 2013; Sabri et al. 2016, 2018). Based on a study of American immigrant and non-immigrant women, in a comparison of the relationship between immigration status and the incidence of IPV, immigrants were found to be "50% more likely to threaten a spouse with a knife or a gun, and approximately twice as likely to force sex and injure a spouse or partner to the extent that medical care is required" (Vaughn, Salas-Wright, Cooper-Sadlo, Maynard, & Larson, 2015, pp. 1899-1900). ISAW survivors of IPV have been documented as being in poorer physical health and experience more sexual health issues than ISAW without IPV histories (Hurwitz, Gupta, Lui, Silverman & Raj, 2006; Raj, Lui, McCleary-Sills & Silverman, 2005). ISAW were further found to be at increased risk for mental health concerns including self-harm, suicide, suicide ideation and attempts (Ahmad-Stout, Nath, Khoury & Huang, 2018; Bhui & McKenzie, 2008; Hunt, Robinson, Bickley, Meehan, Parsons, McCann, & Appleby, 2003). The increased risk to the health and safety of ISAW calls for greater attention and understanding of the need for preventive and intervention strategies that are, specifically, more culturally and linguistically appropriate (Ahmad-Stout et al., 2018; Singh, 2009; Tummala-Narra, Satanni & Patel, 2015).

### 2.5.2. Help-seeking

The pre-migration experience of immigrant South Asian women influences the help-seeking behaviours of women in Canada and in other countries. These experiences are coloured by the strong South Asian patriarchal system, their preference for sons, the dowry system, arranged marriages, forced marriages, child marriages, the sacrament of marriage, marital rape not being a crime in India, and the negative attitudes associated with separated or divorced women, all of which influences attitudes and social underpinnings of IPV and women's social positioning in society (Anitha, 2011). Migration factors result in further isolation, lack of support and knowledge of local resources and laws, as well as financial and psychological stress, (Lee & Hadeed, 2009; Light, 2007; Raj & Silverman, 2002).

The silence and non-involvement of relatives or extended family members are additional factors that were key to the experiences of ISAW with several studies confirming the existence of violence perpetrated by in-laws within South Asian families (Hyman et al., 2011; Fernandez, 1997; Mehrotra, 1999; Bhandari-Preisser, 1999; Watts & Zimmerman, 2002). Consequently, the multitude of factors involving the abuse by extended family members and the socio-cultural and economic factors affected help-seeking by ISAW (Bhandari, 2018; Mahapatra, 2012). Indeed, women in general who are not financially secure do not seek help from formal support services (Gillis, Diamond, Jebely, Orekhovsky, Ostovich, MacIsaac, & Mandell, 2006). Therefore, ISAW are burdened with financial obligations to contribute to their in-law families they live with as a result of arranged marriages and cultural expectations. (Bhandari, 2018; Gill, 2004; Mahapatra, 2012). Increased social isolation is experienced by ISAW as new immigrants, due to their increased vulnerability from lack of social support from friends, family and relatives—often in their homelands. Social isolation, a

common behaviour employed by abusers of IPV to exercise power and control over women, results in low self-esteem and self-confidence which prevents help-seeking and disclosure of the abuse (Gill, 2004).

Immigrant South Asian women experiencing abuse do not adequately access the available healthcare services and police protection (Bhandari, 2018; Jordan et al., 2016). Shirwadhar (2004) maintains that immigrant women often risk violence in their lives and live with the fear of deportation and involvement of the police. It is thus imperative to understand women's needs in order to improve access to healthcare and police services. Culturally appropriate healthcare and police policies and practices can improve access to health and safety of immigrant women affected by IPV (Sabri et al., 2018). Immigrant women's pre-migration experience can influence their decisions to disclose and access violence-related healthcare and police protection. Immigrant women's experiences of migration and acculturation, language, social and cultural barriers are additional factors influencing their delayed help-seeking and access to healthcare and the criminal justice system (Hankivsky et al., 2010).

The threats and danger to the lives of women, their children and natal family members remains real and often results in unreported and undocumented incidences. Importantly, the danger to the lives of ISAW and their families is increased when the natal families are supportive of immigrant women separating from their abusive partners (Campbell et al., 2003, Sabri et al, 2018).

## 2.6. Healthcare and police response

There is wide variation in the reporting of prevalence of IPV globally, ranging from 15% to 71% among the countries studied in a WHO report where physical or sexual violence, or both, is included (Bhandari, 2018; Garcia-Moreno et al., 2006). According to the literature, while shame and keeping silent due to family honour has been cited as key reasons for the lack of disclosures by ISAW, decisions to disclose IPV includes the seriousness and ongoing IPV incidences, availability and knowledge of resources and formal support systems, the effects on children and police intervention due to neighbours reporting the abuse (Bhandari, 2018; Mahapatra, 2012). ISAW are doubly disadvantaged by the very intersections of their immigration status, lack of supportive and informed response by formal services and their cultural beliefs and values (Bhandari, 2018; Tonsing, 2016). According to a multi-location study in the United States, 41% of women killed by their intimate partners were attended to by a healthcare provider one year prior to their death (Sharps et al., 2001).

More recent literature has focused attention on factors that can aid to protect survivors, instead of a primary focus on prevention strategies based on IPV risk factors and, therefore, calling attention to culturally appropriate interventions of risk assessment and safety planning to address the needs of immigrant women (Sabri et al., 2018). While there is evidence in research to indicate that gender and cultural attributes place immigrant women at increased risk of IPV, the risk factors common to immigrant and non-immigrant women remain consistent and include non-consensual sex, strangulation, increasing incidence and severity of abuse and threats to cause serious harm (Campbell et al., 2003; Hyman et al, 2011; Messing et al., 2013; Sabri et al., 2016, 2018; Tonsing, 2016).

IPV survivors emphasise that their ability to disclose to healthcare responders is based on trust, information of resources, and receiving nonjudgmental services for their IPV experiences (Feder, Hutson, Ramsay & Taket, 2006; Kelly, 2009). The ability to identify IPV and respond appropriately and consistently for all women is necessary for healthcare providers and it is essential in the case of immigrant and refugee women due the multiple challenges they face (Sabri et al., 2018).

## 2.7. Challenges to help-seeking behaviour and disclosure

Previous research relating to the barriers of reporting to formal services such as police, cited culture and the fear associated with stigmatisation and the lack of support for immigrant and refugee women including South Asian women (Ahmad et al., 2009; Horn, 2009; Shalabi et al., 2015). Hence, more immigrant and refugee women sought informal supports of friends and family instead of formal systems such as police, due to prior experience of racism and discriminatory actions (Sabri et al., 2018).

According to Ansara and Hindin (2010), studies have documented the numbers of survivors of IPV, as well as attributes of the criminal justice system. However, the focus of these studies remains the usage of the criminal justice lens instead of a healthcare one. The study further noted that this conceptualisation narrows the experience as physical violence only, and fails to understand the mental health and emotional nature of the power and control components prevalent in these situations (Ansara & Hindin, 2010). As a result, the healthcare consequences and the help-seeking behaviours of survivors are not correctly understood.

Data from the 2004 Canadian General Social Survey concludes that the severity of the abuse was associated with formal reporting to healthcare, shelter and crisis centres and police services and was indicative of help-seeking behaviours for survivors, whether they seek formal or informal help for the abuse they faced (Ansara & Hindin, 2010; Hyman, Forte, Du Mont, Romans, & Cohen, 2009,). The results further suggest that research completed in a sensitive way, inclusive of people's experience of violence and power and control issues, can be better predictors of their health and safety needs and, in turn, provide a clearer indication of the services required. Help-seeking among ISAW has been viewed as a complex and complicated process due to the multiplicity of barriers that they confront and the prominent role of extended family structures, values and the role of in-laws (Ahmad-Stout et al., 2018; Wasim, 2014). Notably, ISAW relied on informal supports of family and friends, while the reasons for leaving often include the safety of children, the support of natal family members and supportive community supports including immigrant serving services or practitioners (Dasgupta, 2011; Mahapatra, 2012; Raj & Silverman, 2007).

Vulnerable and marginalised populations have been observed to receive poor quality of care and have reduced levels of access to healthcare as a result of institutional discrimination and cultural racism, combined with institutional processes (Williams & Mohammed, 2013). The notion of institutional racism was also discussed in the literature, relating to police responses to ISAW in the UK, where it is believed to be not completely understood. It was further remarked that literature paid little attention to the experiences of women in their interactions with the police, both in the contexts of crime and race (Belur, 2008; Gill & Harrison, 2016; Anitha, 2008). As a result, women were marginalised due to the lack of sufficient services

for ISAW survivors and the inability by police to meet the need of ethnically diverse women as identified by previous research (Hoyle 1998; Patel, 2003).

Despite various research efforts to address the marginalisation based on the culture of the survivor, there is also literature on the minimisation of the issue of IPV in general, with regards to the police culture of response to IPV (Belur, 2008; Brown, 2000; Hoyle, 1998). This results in the reluctance of ISAW to seek help from the police, in fear of what can happen to them, their spouse and children and the lack of a linguistically and culturally informed response by the police.

Another significant area of focus in the literature were situations where the police officers are from the same culture as the ISAW. As such, police officers are noted to be uncomfortable with the identification of the IPV survivor and, instead of the presumption that this has the benefit of the language and cultural understanding, results in a less appropriate or poor response to the call for help (Belur, 2008; Sharp & Atherton 2007). Based on the study by Belur, (2008), there were several factors that affected the police response to ISAW. These included inadequate and appropriate interpretation services, institutional discriminations, lack of understanding of the challenges facing ISAW in situations of IPV, socio-cultural barriers, lack of knowledge of resources, and lack of culturally trained responses.

## 2.8. Health and safety of immigrant women

The studies completed by Canadian and BC researchers are limited to a single focus: either the police or the healthcare systems without study of their intersection. In addition, these studies document the experiences of women but not the specific experiences of ISAW. Jiwani et al., (2001), in her research, looks into the experiences of ISAW when they seek medical services. Again, this is a single focus study without the safety lens. Jiwani highlights the fear or lack of confidentiality facing women when they seek medical attention from their family doctors due to the presence of the spouse or in-laws during the consultation. The comfort and knowledge to seek police protection often presents a further barrier due to the lack of trust, based on their knowledge of the police in India, fear for the spouse as they express only wanting the abuse to stop, or the immigration or removal of their children (Ahmad et al., 2009; Jordan et al., 2016; Messing et al., 2015). The consequences of seeking help is a complex and difficult one. Once again, this cannot be understood with a ‘one size fits all’ view, including their experiences, police and healthcare response received, or the risk identification and assessment tools and, most importantly, the safety planning that is required for ISAW (Messing et al., 2013; Sabri et al., 2018).

### 2.8.1. Understanding culture

Understanding the specifics of a community and their culture remains central to healthcare and police responses as cultural norms and language are barriers for immigrant women accessing help (Finfgeld-Connett & Johnson, 2013; Sabri et al., 2018; Salabi et al., 2015). Cultural factors may delay women’s help-seeking but it should not be a barrier for responders. The ability to communicate proficiently in English is a challenge for many immigrant women, and thus the provision of sufficient translation and interpreting

services to ensure the health and safety of women needs to be a component of service delivery (Bhandari, 2018; Sabri et al., 2018). Consequently, the culture of a woman should not influence the service she receives. Along similar lines is the notion that IPV should be recognised as a crime against an individual, initiating complex health and safety concerns for immigrant women. Knowledge of IPV and the magnitude of its impact on the lives of immigrant women aids the timely identification of IPV, risk assessment and safety planning in situations of women suffering from multiple injuries, the severity of injuries and increased risk to fatalities and potential mortality (Messing et al., 2016; Sabri et al., 2018). Being equipped with knowledge of culture, IPV, policy and practices, and prevention and intervention tools and means, is the responsibility of the healthcare and police responder (Jordan et al., 2016; Williams et al., 2013). In fact, the identification of injuries and health concerns as a result of IPV should be comparable to the identification of symptoms of other illnesses and causes. It is the understanding of symptoms and its causes that form the basis of prevention and intervention strategies, in order to curb prevalence of IPV, a global public health concern (WHO, 2002, 2016). Similarly, in the case of police response, the safety of an IPV survivor requires the knowledge to aid IPV identification, and provide timely and appropriate prevention and intervention strategies (Davies, Lyon & Monti-Catania, 1998; Jeffrey et al., 2018).

The concept of safety and safety planning continues to face continuous development and enlargement by feminist researchers and scholars working in this area (Doherty, 2017; Guruge & Humphreys, 2009; Sabri et al., 2018). The literature continues to expand its discussion and theorising of physical and emotional safety, while cultural safety is not understood within the application of prevention and interventions strategies affecting immigrant women. Cultural safety was first developed as an educational framework by Irihapeti Merenia Ramsden to acknowledge the power differential between healthcare practitioners and their patients (2002). Cultural safety within the Canadian nursing context has been framed to promote equality and social justice in knowledge and practice (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam & Wong, 2009). Cultural expectations and social norms play a critical role for ISAW, yet this understanding has not been researched thoroughly. One gap that remains is data regarding the prevalence of abuse that occurs within immigrant communities in general. Researchers have not collected such data for reasons that could further stereotype and stigmatise immigrant communities as more violent and, as a result, create a negative impact on the males in the community (Gurm & Cheema, 2013; Thandi et al., 2011; Vandello, & Cohen, 2003, WHO, 2009).

## 2.9. Interventions

Research studies focused on IPV prevention and improving service response recommend culturally appropriate services that are specific to the IPV experiences of particular communities (Bhuyan & Senturai, 2005; Mason & Hyman, 2008). Although, an understanding of the cultural identity influencing the values and beliefs held by a woman is further influenced by the interrelationship of an individual's race, gender and immigration experiences that contribute to inequalities and stigma, delaying the departure from IPV situations (Bhuyan & Senturai, 2005). It is important to note that IPV services within the Canadian context

have been developed in conjunction with the socio-cultural values that reflect white Canadian-born women and, therefore, have limited applicability to immigrant women (Bui, 2003; Guruge & Humphreys, 2009; Jeffrey et al., 2018).

The support of formal responders to IPV remain important but it is critical that they are IPV and culturally informed, as well as having knowledge-appropriate resources (Sabri et al., 2018). The education and training of responders remains an important element in the health and safety of ISAW. The potential to improve the healthcare service delivery for marginalised communities can be accomplished with the existence of multiple opportunities and with the development of ways to increase access and care (Williams & Mohammed, 2013). A further suggestion by Williams and Mohammed (2013), based on a review of the research across disciplines, encompasses several strategies to close the gap between policy development and scientific, evidence-based research of interventions, that achieve equality in service delivery and greater communication across sectors and disciplines (Katz, 2009).

Programs have been developed to provide support to IPV survivors (Bhandari, 2018; Williams et al., 2013). However, they remain in training manuals due to the lack of staff time or resources to implement or maintain these resources (Williams et al., 2013). The question remains: how safe and supported do immigrant south Asian women feel to disclose the abuse when they seek medical attention? Despite the suggestions by researchers and healthcare practitioners for screening tools use, according to Allard (2013), many survivors attending emergencies are not screened by healthcare professionals. The study completed by Jiwani et al., (2001) highlighted that healthcare professionals do not have the time to ask appropriate questions or feel that they do not have the right information to make appropriate referrals. Both of these situations leave immigrant South Asian women further vulnerable to continuing abuse. Increasing focus is now on the high economic, social and healthcare costs associated with domestic violence. Black (2011) suggests that the prevention and intervention of domestic violence can reduce these costs in addition to improving the health of patients. Hence, it is important for healthcare practitioners to ask not only about physical or sexual violence, but also of the emotional and other signs of IPV. This would facilitate the timely identification of health and safety risks, particularly of significance for ISAW, due to their delayed disclosures of IPV (Ahmad et al., 2009; Ahmad et al., 2017).

### 2.9.1. Identification and assessment of risk

Research focused on increasing the number of women seeking help for IPV offer several approaches for service intervention or response to the issue. Healthcare and police responses to IPV of immigrant women continue work to efficiently or effectively assess the risks confronting them in situations of IPV (Light, 2007; Sabri et al., 2018; Wolf, 2003). Assessing and responding appropriately to abuse and injury within the healthcare and other support services should be done regularly by practitioners (Bhandari, 2018; Jordan et al., 2016; Sabri et al., 2018). In many cases, disclosure of the abuse to medical and police staff can increase the risk of injury and endanger the lives of women and their children (Allard, 2013; Olive, 2007). It is critical

that the confidentiality and the safety of the women and her children be of paramount concern for the practitioner.

Risk assessment is a means to ascertain the existing risk factors and evaluating the possibility of recurring IPV, while safety planning examines the opportunities to address the risk factors present (Jeffrey et al., 2018). Safety planning strategies encompass ways a woman can protect herself and her children from the potential harm of a current or former spouse (Campbell, 2001; Jeffrey et al., 2018; Murray, Horton, Johnson, Notestine, Garr, Pow, & Doom, 2015). Asking a woman about the danger or risk she faces has been found to be as good a risk predictor as any assessment tool and furthermore no single assessment tool is more accurate (Hanson, Helmus & Bourgon, 2007; Gurm, Salgado, Marchbank & Early, 2020).

In contrast, lack of safety planning and appropriate referrals to services could increase the risks of injury or death (Campbell et al., 2003; Messing and Campbell, 2016; Sabri et al., 2018). Immigrant South Asian women face the added complexity of barriers that include, but are not limited to, the fear of deportation, fear of losing their children to the extended families or their spouses, the interaction with the justice and police systems, situations of dual arrests (where the victim of the abuse is arrested as well as the abusive spouse), language barriers, social and community isolation, economic and financial consequences, among others (Kulwicki, Aswad, Carmona & Ballout, 2010; Jiwani, 2006; Light, 2007).

The importance South Asian women attach to family values and expectations upon themselves after marriage, contributes to abuse by their in-laws (Ahmad-Stout et al., 2018; Wasim, 2014). It is imperative that practitioners understand the beliefs and perceptions of ISAW as significant factors affecting women's reluctance to take action to resist IPV (Finfgeld-Connett & Johnson, 2013). Immigrant women's lack of trust, concern about the breach of confidentiality or the contact of abusive spouses or in-laws with practitioners, are notably significant elements in the development of prevention and intervention practices and policies (Ahmad-Stout et al., 2018).

Healthcare practitioners were cautioned to provide appropriate referrals and supports to ISAW beyond the IPV disclosures, as women may confront challenges disclosing or gaining support around their suicide ideation, recognised as a potential impact of IPV (Ahmad-Stout et al., 2018). It was also emphasised in their risk assessments that, while supporting safety planning, practitioners remain cognisant of family relationships, structures and socio-cultural reasons for immigrant women staying in, or leaving, their IPV relationships (Ahmad-Stout et al., 2018).

ISAW delay IPV disclosures to healthcare practitioners while enduring the abuse for several reasons. It includes the shame and stigma associated with identifying as IPV survivors, and its consequences for themselves and their natal families, often resulting in prolonged efforts by them to maintain the family unity while considering the welfare of the children (Ahmad et al., 2009). The role of the healthcare system and practitioners at various points of contact with immigrant women remain of particular significance in providing supportive care, nonjudgmental medical services, while ensuring timely and appropriate IPV referrals for safety and community resources (Ahmad et al., 2009; O'Campo, Ahmad & Cyriac, 2008). Research

confirms that responders with the appropriate and culturally relevant training and professional care are pertinent for all women, including ISAW, to seek timely services to remain safe and healthy (Ahmad et al., 2009; Sabri et al., 2018).

Equitable and improved healthcare service delivery, with multi-faceted interventions, can reduce challenges to care due to socio-cultural barriers and disparities in service delivery (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2003; Williams et al., 2013). A critique of culturally relevant training and programs is that these initiatives lack a theoretical foundation and are unsuccessful at evaluating the impact they achieve (Er-Rafiy, Brauer, & Musca, 2010; Williams et al., 2013). Additionally, it has been noted that culturally relevant and diverse initiatives and training has not only been consistently documented, but there is also no sufficient evidence to confirm its gains to achieve diversity based on organisational performances (Curtis & Dreachslin, 2008; Williams et al., 2013). While risk assessment tools can minimise safety concerns and aid with safety planning, it is important to note that not only could these tools potentially violate a woman's right to choice and respect, but the evaluation of these tools are also in its initial stages (Jeffrey et al., 2018; Johnson, 2010; Nicholls, Pritchard, Reeves & Hilterman, 2013).

According to Jeffrey et al., (2018), culturally-informed and immigrant-specific risk assessment and safety planning have not received research attention. The development and validation of risk assessment to aid the prediction of the severity and frequency of violence and homicide for immigrant communities requires further research (Jeffrey et al., 2018).

## 2.10. Chapter Summary

This chapter presented the review of the literature about ISAW, their experiences of IPV – including the barriers they are confronted by, and the healthcare and police response to ISAW which provided critical information for the study. Not only is the area of IPV a public health issue with serious impact for the ISAW, it is an issue that remains to be researched on a small scale. The unique intersection of healthcare and police response in the IPV is significant as these are two systems that provide a public service and can have critical impact of the health and safety of ISAW. An understanding of the societal patriarchal structures influence the incidence of IPV, as power and control are its key attributes. This patriarchal structure is further magnified for ISAW when they face additional challenges upon migration to western countries and have to seek help from formal systems of healthcare and police. The literature provides insight into the institutional and service challenges ISAW are further impacted by, when they seek healthcare and police services.

# Chapter 3. Research Methods

## 3.1. Introduction

This study was designed to examine and understand the needs of ISAW in British Columbia, Canada, experiencing IPV while interacting with healthcare, community social services and police services. A modified exploratory sequential mixed methods design was employed for the study, and this chapter describes the selected research methods to understand the experience of IPV among ISAW.

Chapter 3 presents a discussion of the study's research design, philosophy, and approach with a discussion regarding its advantages and disadvantages. The chapter outlines the mixed methods approach, the processes of recruitment, sampling, analysis, and interpretation. The associated ethical and safety considerations, relating particularly to the participation of ISAW survivors of IPV, are in the study and the study settings are provided, followed by a discussion of the qualitative and quantitative elements of data collection, analysis, data quality and validity.

## 3.2. Research Design and Overview

The study's research questions were addressed using a modified exploratory sequential mixed method. The research questions were:

1. What barriers do ISAW face when disclosing IPV to community social services, healthcare and police?

2. How do community social services, healthcare and police, respond to IPV experienced by ISAW?

3. What interventions by community social services, healthcare & police can improve the safety and well-being of ISAW in BC?

The exploratory design was deemed appropriate and most applicable when researching a complex phenomenon such as intimate partner violence (Creswell, 1998, Creswell, Clark, Gutmann & Hanson, 2003). A modified exploratory mixed methods design was considered appropriate for the study in order to answer the research questions, and also based on the fact that little was known about the subject of IPV of ISAW in BC with regards to their experiences with the healthcare and police services. Employing an exploratory design based on the research problem and purpose placed a greater priority on the qualitative phase as it provided the study with a deeper understanding of IPV of ISAW and the potential for determining resonance with other immigrant women survivors and service providers (Morse, 1991).

The utilisation of a mixed methods sequential exploratory design guided the two-phase data collection:

**Phase One** Four Women's focus groups.

Service providers' focus group.

Semi structured key informant interviews.

**Phase Two** Provincial online survey.

The modified mixed methods research procedure entailed conducting the qualitative data collection phase first, followed by the quantitative data collection. The exploratory sequential design utilised in this study was modified, as the first phase qualitative data collection and data analysis did not inform the development of the secondary quantitative phase. Instead, the quantitative phase survey was an adaptation and modification of previous community based research conducted with immigrant women in BC. Furthermore, the qualitative data analysis was done prior to the quantitative data analysis. The qualitative data were gathered as part of Phase One from the three qualitative data sources: women's focus groups, service provider's focus group and key informant interviews. The qualitative data was drawn from a convenience sample of participants. The ISAW women's focus groups were recruited through the organisations where they had sought help. The service providers' focus group participants were senior level management staff who were contacted to attend the focus group. The key informants were experienced policy makers, policy analysts and management professionals, identified and invited to participate in semi-structured interviews to provide insight into the challenges and potential improvements for health and safety incidences of IPV of ISAW. Data were more completely elaborated and clarified by the descriptive Phase Two quantitative data results, from the provincial online survey of the community social services, healthcare and police responders.

## 3.3. Philosophical Assumptions

Pragmatism is the core philosophy of mixed methods and can be credited to the work of John Dewey, William James and George Herbert Mead (Johnson & Onwuegbuzie, 2004). Pragmatism places emphasis on the practical results of the research and the importance of the research questions, rather than the methods employed with the choice of using multiple methods for data collection to guide the research (Creswell & Clark, 2011). The pragmatic view has been commonly adopted by mixed methods researchers (Tashakkori & Teddlie, 2010).

The first years of the development of mixed methods research has been referred to as the formative period (Creswell & Clark, 2011, 2017). The 'paradigm wars' period presented debates over mixed methods research. The 'paradigm wars' of the 1980s, between traditional quantitative researchers defending the dominance for the positivist approach against the constructivist approach, have been well-documented (Johnson, Anthony & Turner, 2007). Mixed methods has been argued to provide a solution to the paradigm gap for the opposing positions held against the mixing of the positivist paradigm (quantitative) and constructivist paradigm (qualitative) (Sandelowski, 2000; Johnson et al., 2007).

Although mixed methods is not the perfect approach for all research questions, there are workable solutions that can aid the work of researchers using this method (Johnson & Onwuegbuzie, 2004). Consequently, multiple worldviews were applicable across the two phases of this research study, relating to its main objective (Creswell & Clark, 2017). The study applied a community-based feminist-centred lens by seeking the participation and voices of women survivors in the four focus groups to document their challenges and acknowledge their social and cultural constructs (Hankivsky et al., 2010; Narayan, 2000).

## 3.4. Mixed Methods Design

Mixed methods approach, also known as the third research paradigm, has been documented in the literature since the 20th century, in addition to the well-known and used 'quantitative' and 'qualitative' research approaches within a single study (Creswell & Clark, 2011). Qualitative methods allow the researcher to answer questions exploring the 'what' and 'how', to gain deeper insights and understanding of central issues whilst the measurement, prediction and relative understanding of the research findings can be further understood through the utilisation of quantitative methods (Creswell, 2013, 2013b). Mixed methods research permits the augmentation of the strengths of qualitative research for the weaknesses of the quantitative research and vice versa (Johnson & Onwuegbuzie, 2016).

The literature has defined the mixing and combining of quantitative and qualitative data as mixed methods, 'multi-method' or 'integrated' research approaches (Tashakkori & Teddlie, 2003). The collection of data, data analysis and mixing and combining quantitative and qualitative data into a single study or series of studies has been defined by Creswell, (2009) as the mixed methods approach. Inductive and deductive reasoning techniques are amalgamated in order to derive accurate answers to the research questions, in cases where neither a quantitative nor qualitative approach would be applicable or appropriate alone (Denzin & Lincoln, 2000). According to Creswell and Clark (2017), mixed methods research involves both philosophical assumptions and multiple methods of inquiry. In the current study, core philosophical assumptions of pragmatism guided the methodological approach selected.

Despite the continued discussions among the traditional paradigms of quantitative and qualitative approaches to maintain dominance, mixed methods does offer a perspective for conducting research. Mixed methods contributes to addressing research questions that require a complex understanding of research processes (Johnson et al., 2007; Schwandt, 2006; Twinn, 2003).

## 3.5. Mixed Methods Advantages and Disadvantages

Mixed methods research presents an opportunity to construct a research study based on the strengths of both qualitative and quantitative data. While the quantitative data lends a perspective informed by statistical analysis, the qualitative results may or may not provide the descriptive answers to the research questions (Leech & Onwuegbuzie, 2009; Creswell & Clark, 2011). Additionally, the qualitative narratives can increase understanding and enhance the analysis of the quantitative relationships informed by the statistics.

As the current research focuses on interdisciplinary, dynamic and complex topics and issues, it is imperative that a variety of methods are used to accomplish the goal of clearer understanding, improved research results and increased promotion of collaborative efforts (Johnson & Onwuegbuzie, 2004, pg. 15). The use of a mixed methods design offers various benefits. According to Polit and Beck (2006), the advantages of mixed methods design include being complimentary, incremental, enhancing validity and creating new perspectives. Mixed methods are complementary where both qualitative and quantitative data includes the narrative and statistical representation of data within a single approach, thereby avoiding limiting data

collection to a single method (Teddlie & Tashakkori, 2009). The incremental progression of mixed methods lends in-depth exploration possibilities of qualitative findings for quantitative data clarifications, whilst qualitative findings can be tested quantitatively for the generation of hypotheses (Ivankova, Creswell & Stick, 2016; Polit & Beck, 2006).

Mixed methods have value in addressing a range of perspectives in response to specified research questions (Williamson, 2005; Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2003). Mixed methods permit the balancing of the strengths and weaknesses within a single study, made possible by the combination of qualitative and quantitative data that complement each other and hence, support a more complete analysis of the research results (Greene, 2006). The four advantages of this integrated design were identified by Polit and Beck (2004): complementary strengths and weakness, incremental advances in knowledge within a single study, improved validity of study objectives and, where the results are incongruent, opportunities for further study.

Mixed methods has its challenges and these include being time and resource intensive and making it essential that the timeline for the study is well planned to enable the completion and accomplishment of the study objectives. The multiple data collection phases and data analysis requires multiple steps (Creswell, Clark, Gutmann, & Hanson, 2003). Understanding the precise combination of quantitative and qualitative designs within a single study is another challenge facing researchers using mixed methods.

## 3.6. Rationale for Mixed Methods Study Design

The mixed methods design provided a context within which the combination of mixed methods rationalised the findings. This provided more depth and articulation of the gaps and possible solutions pertaining to the experiences of ISAW in BC. The study design enabled the expression of diverse views and understandings of the gaps and possible solutions to create and increase the safety and health of ISAW in situations of intimate partner violence. It brought together the researchers' and ISAW perspectives in addition to that of practitioners and policy makers through both the qualitative and quantitative data findings. Enhancements were more readily possible with the availability and reference by way of inferring or augmenting the data and findings of the mixed methods design, instead of utilising either the qualitative or quantitative research design.

There were several reasons that supported the selected modified exploratory design including the potential for generalisation, the study and researcher were more qualitatively oriented, and the researcher had the time to design and conduct the data collection and analysis in two sequential phases (Creswell, 2011). The complexity of the phenomenon of intimate partner violence benefited from the utilisation of mixed methods design, whereby the qualitative data from a smaller multi-group purposive sampling was enhanced by the larger quantitative online survey of provincial frontline responders.

A more complete and comprehensive account of the study of ISAW experiencing IPV was possible with a mixed methods design, instead of being limited to a single design of selecting either the qualitative or

quantitative mode of inquiry (Johnson, Onwuegbuzie, & Turner, 2007). A process of understanding the study was also possible with the account of the small sample of survivors, service providers and policy makers against the larger perspective of provincial frontline responders through the online survey. The integration of the qualitative and quantitative data in the final stage was used to explain the results generated and, in particular, where unexpected results were generated within either data set (Creswell & Clark, 2011).

## 3.7. Mixed Methods Design Decisions

The research design typologies and their possibilities remain limitless (Teddlie & Tashakkori, 2003), and several researchers have developed typologies that have not met the needs of researchers and, according to Leech & Onwuegbuzie, (2009), has resulted in their attempt to introduce three-dimensional mixed methods research designs. This explains that a study design could encompass either a fully mixed methods or a partially mixed methods design. The fully mixed design is one where the qualitative and quantitative data are mixed within or across one or several stages or research processes, while for the partially mixed design, the qualitative and quantitative methods are only mixed at the final stage of the interpretation of the data, which employed either a concurrent or sequential mode in conducting the study. These eight, three-dimensional research designs are conceptualised on the level of being fully or partially mixed, having a timing component of either being concurrent or sequential, and placing dominance on either the qualitative or quantitative data (Leech & Onwuegbuzie, 2009).

According to Creswell and Clark (2011), four main mixed methods research designs exist: triangulation, explanatory, exploratory and embedded. The triangulation design supports both qualitative and quantitative data collection at the same time and often with parallel analysis. The triangulation design is used for comparison of qualitative and quantitative evidence for validation and identification of inconsistencies in data sources (Creswell & Clark, 2011). The effective use of mixed methods has clear benefits in the case of triangulation, such as highlighting convergence, complementarity and dissonance (Morgan, 2007). Furthermore, Morse (1991), has clearly argued that triangulation in qualitative methods can be enhanced by the combination of the results of quantitative methods.

The explanatory design utilises the qualitative data to describe or expand on primary quantitative findings or in research when quantitative findings focus on the selection of participants for qualitative exploration (Morgan, 1998; Morse, 1991).

In the case of the exploratory design, the first phase qualitative data collection and data analysis informs the development of the secondary quantitative phase for an overall outcome of testing or generalising the initial qualitative results. This design is appropriate in research where there is a lack of theoretical framework, instruments or variables, or with a phenomenon that needs to be qualitatively explored before measurement or testing (Creswell & Clark, 2011).

Finally, the embedded design uses one type of data, either qualitative or quantitative method, to support the other method (Creswell & Clark, 2011). The qualitative or quantitative methodological framework directs the study, enabling additional data collection at any phase to support and enhance the study findings (Creswell, 2013), and it also allows mixing and merging data at both the data and design levels (Greene & Caracelli, 1997; Creswell et al., 2008).

According to Creswell & Clark (2011), there are also four main deciding factors when selecting a mixed methods approach. These are the level of interaction, the dominance of either the qualitative or quantitative design, the timing used and the mixing procedures for the research study. The basic process of conducting a qualitative or quantitative study, according to Teddlie and Tashakkori (2009), encompasses presenting the question, data collection, analysis and interpretation.

The distinguishing features of mixed methods research are its timing, weighting, mixing and combining quantitative and qualitative data within a study (Creswell, 2013). The timing of collection and integration of the data using different methods and analyses remains important (Morgan, 1998). Data are collected and analysed either concurrently or sequentially (Johnson & Onwuegbuzie, 2004). A concurrent phase is the collection of qualitative and quantitative data simultaneously. Sequential designs involves the sequencing of the methods one phase at a time.

Mixed methods emphasise either equal or unequal weighting of the qualitative or quantitative data for the purpose of the study (Morse, 1991). The quantitative and qualitative methods can be weighted equally or unequally, thereby placing dominance on either the quantitative or qualitative methods (Leech & Onwuegbuzie, 2009).

The mixing of the qualitative and quantitative aspects of the data and findings occurs through the merging of the two data sets, in connected or in embedded ways (Creswell & Clark, 2011). The merging of the data takes place either during the data analysis or during interpretation and discussion, as in the triangulation design (Creswell & Clark, 2011). In the case of connected research studies, the findings are linked in their results as apparent in explanatory and exploratory designs (Creswell & Clark, 2011). Embedded designs differ in the mixing of the data, as it can occur at the data and design level where the types of data are used within the context of the other method (Creswell & Clark, 2011).

In this study, dominance was placed on the qualitative data with the merging of the data taking place during the integration and interpretation of the results. The researcher integrated and interpreted the qualitative and quantitative results to understand the ways in which the quantitative results expanded the understanding of the qualitative findings.

There are several advantages and strengths of the modified exploratory sequential design chosen for this study. The two separate phases of the design made the study easily describable, implemented and reported, while the emphasis remained on the qualitative design of the study, with the quantitative aspect of the study providing more strength and understanding of the findings. This design had the potential for

the development of a new understanding into a complex nature of IPV of ISAW, who are in a disadvantaged, vulnerable and compromising position. This research design came with its own challenges and these included the two phase design demanding considerable time allocation for the data collection, although it was factored into the study. The qualitative phase of the study included extensive travel and demanded more time of the researcher in order to incorporate the diversity of the geographical locations of ISAW within the province of BC, while lending a wider perspective lens to the research study (Creswell, 2011).

The approach employed by this study provided the insight for improving responses to IPV (Hankivsky et al., 2010). This study was designed for ISAW instead of about them and strived to gain meaningful participation with the communities of ISAW. The study allowed the combination of systems and social and cultural constructs in order to comprehend and address the responses of healthcare and police services against the experiences of ISAW (Hankivsky et al., 2010).

The focus on partnership with community workers involved survivors from community agencies and the engagement of service providers and stakeholders working in the field, which could enrich the research findings dissemination and application by assisting their translation into appropriate service delivery policies and programs that the participants themselves could benefit from (Hankivsky et al., 2010). The involvement of community workers and stakeholders in this study guided the process by keeping it accountable, relevant, representative, appropriate, and current, while grounding the analyses in the lived experiences of the women (Hankivsky et al., 2010).

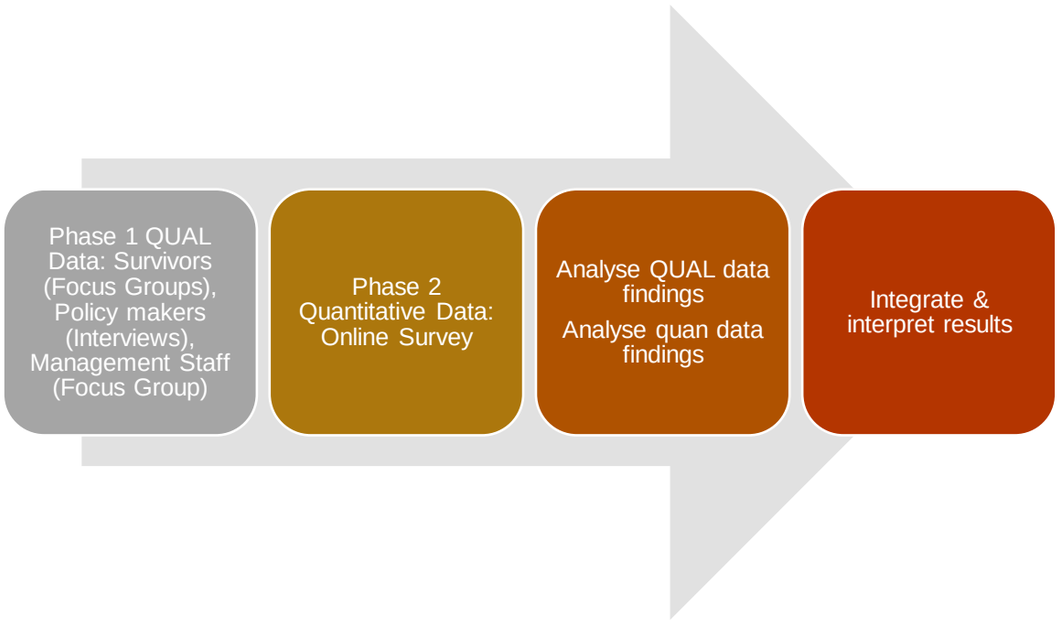



**Figure 3.1: Research study phases of a modified Exploratory Sequential approach**

The qualitative data were gathered as part of Phase One from the three qualitative data sources: women's focus groups, service provider's focus group and key informant interviews. Data were more completely confirmed, explained and clarified by the Phase Two quantitative data results, of the provincial online survey of the community social services, healthcare and police responders (Figure 3.1).

The researcher's decision to begin with the qualitative data was in line with the notion that there is no prescribed way for any method, other than one that fits the reality of research (Sandelowski, 2010). The researcher placed priority on the qualitative data because the objective of the study was to understand the experiences and challenges faced by ISAW and service responders.

## 3.8. Research Setting

The study was conducted in four community social service organisations, one in each of the following cities in the Province of British Columbia: Vancouver, Abbotsford, Kelowna and Prince George. These four sites were selected based on the population density and distribution of immigrant South Asian communities and was representative of the rural and urban spread as depicted in Figure 3.2 (Statistics Canada, 2011).


**Figure 3.2: Study setting**

The selected cities and organisations had provided crisis and practical assistance to the women on their journey of leaving their abusive relationships. The researcher had also worked closely with the organisations and this facilitated access to the women participants and the organisations. The four cities provided the views and experiences of ISAW from across the province when accessing healthcare and police services. The organisations were approached to obtain approval from the administration to facilitate the sessions at their offices, advertise for participants, recruit, and ensure that workers were present during the sessions to ensure that the participants were comfortable with the presence of a familiar person. The explanatory statement was emailed to the organisation worker prior to the session (Appendix B).

The service provider's focus group was conducted in Vancouver, as it was considered central for these service providers. Key informant interviews were conducted at their offices and scheduled based on their availability. All of the interviews were conducted in Vancouver, except for one, which was conducted in Burnaby.

## 3.9. Phase One

The qualitative population included three groups: women survivors of IPV in the province of BC, service providers, representatives of management and senior staff and key informants, and subject matter experts in policy, government and provincial services.

The purposive sampling of the qualitative data set was smaller, compared to the larger quantitative data set, and provided a wider and more diverse representation of the research problem. The utilisation of the mixed methods design further enhanced the credibility of the approach and the integrity of the findings without limiting or compromising it. While the utilisation of the modified sequential exploratory design allowed the engagement of various voices: IPV women survivors and the service providers through focus groups, key informants interviews of policy makers of the anti-violence sector and that of the community social services, healthcare and police services through the province-wide online survey.

### 3.9.1. Women's Focus Group

Focus groups were selected as the data collection method for the women survivors due to several reasons. The study acknowledged the vulnerabilities faced by the ISAW in reiterating their traumatising experiences of IPV during their interactions with healthcare and police. The qualitative data collection of the four women's focus groups entailed the travel to four different geographical sites. The researcher was mindful of the weather conditions that could have affected the attendance at the focus groups, particularly in Prince George, and Kelowna. Both of these cities required travel by the researcher and women to attend the focus groups. The focus groups were planned for the summer to ensure that travel was safe and possible for the women due to weather conditions and distance. The focus groups were conducted in offices where they had previously received supportive services after leaving their abusive relationships.

Participating in a group with other ISAW who experienced IPV created a space that was supportive for them. The recruitment of the women was undertaken in collaboration with the staff and community social services organisations that were familiar to them, thus reassuring their possible concerns for safety. The focus groups provided the safety net of the familiar place, support person and possible follow-up services if needed. The women were assured of their confidentiality and anonymity upon recruitment and during the focus groups. The focus groups provided a place to share as much or as little as they were comfortable with as they were among other women. It minimised the stigma and shame of being a survivor as they were among other ISAW. The focus groups, as a result, provided a safe space for them to revisit the actions they had undertaken after they left their abusive relationships. Focus groups were thus selected as a method for ISAW to feel safe and among other ISAW, creating a supportive environment to share their challenging journeys.

### 3.9.2. Sampling

According to Patton, (2002) there is a lack of rules regarding sample size in qualitative research studies, which commonly involve small samples. In general, the sample size is adequate when data saturation is reached (Creswell, 2009). Purposive sampling was used in recruiting participants for Phase One.

Saturation, as explained by Teddlie and Tashakkori (2009), does not result in the provision of new information.

#### *Inclusion criteria*

This group consisted of ISAW who had experienced IPV in their relationships in each of the four data collection sites. The focus groups were limited to immigrant women 18 years of age and over, from the Indian subcontinent, who spoke English and had experienced IPV. The group included women who were immigrants or had parents who were immigrants.

#### *Exclusion criteria*

The focus groups excluded women who did not access healthcare, police or community social services. Women below the age of 18 years of age were also excluded. The groups further excluded women who experienced non-partner sexual violence, and who did not speak any English. Women who did not feel comfortable with their command of the English language did not participate. The groups were conducted in English, although a bilingual community worker was available during the sessions to provide translation, only in situations where women found it easier to express certain experiences and words in their own languages – mostly in Punjabi and Hindi. Twenty-two ISAW attended the four regional focus groups.

### 3.9.3. Procedure

Women were recruited via a flyer advertisement at the organisations where they accessed support or services for the IPV they experienced. The flyer was posted at the organisations. The potential participants had the opportunity to call or email the researcher or the worker from the organisation for questions and obtain the Explanatory Statement with details of the study. The participants signed the consent form prior to attending the focus group session. See Appendix D for flyer advertisement and Appendix A for the consent forms.

An important consideration was safe advertising of the study for recruitment purposes. This included advertising through the community social services organisation, and interested participants provided with the relevant information upon request. Pertinent information such as the venue, date and time of the session, and contact information of the researcher, was included in the flyer.

Understanding the increased complexity and vulnerability of immigrant women due to culture, immigration status, justice system involvement, ethnicity, disability, sexual orientation, or substance use, among others, was central to the development and utilisation of this recruitment design. Cultural sensitivity included key elements of cultural values and beliefs, patriarchal structures, religious beliefs and practices, differing understanding of intimate partner violence, establishment of trust, confidentiality, language barriers, stigma/loss/grief/traumatisation, and country of origin experiences, immigration status, new homeland adjustments and acculturation/justice system (Ahrens, Isas, & Viveros, 2011; Bent-Goodley, 2007). It was crucial that the researcher understood the sensitivities brought to bear by values and beliefs influencing how women responded to sharing their personal and traumatic experiences. This is often the case, even

after they have left their abusive relationships. It was the trust-based relationship and environment that increased their participation and willingness to share openly.

No specific culturally sensitive and safe recruitment design applicable to ISAW was found. Hence, culturally sensitive and safe valid questions were developed for the recruitment phase of the study of ISAW survivors. Contributions made by researchers, including Fontes (1998, 2004), and Ellsberg and Heise (2002), in the area of ethics and undertaking research with vulnerable populations, by Langford (2000), for informing the safety considerations of conducting research with IPV survivors and in conducting ethno-culturally sensitive research, were foundational to the development of the focus group questions (Mechanic & Pole, 2013). Community based projects undertaken in other areas were also instrumental in designing the questions (MOSAIC, 2015).

The focus group questions were read to the participants in English. The bilingual worker and researcher translated the questions into Punjabi or Hindi in situations where the participants required further clarification. The questions had been forwarded to the bilingual worker prior to the focus group and shared with participants who requested more information. The focus group discussions were audio-taped and later transcribed verbatim. Each session took approximately an hour.

#### *Interview questions*

Multiple and varied interview questions were designed to allow participants to share their experiences in the least distressing sequence (Appendix C). It was important to understand the challenges they faced when accessing healthcare and policing services while remaining safe. Peer feedback remains an integral part of accountability and informal feedback from community social service peers was received, to guide the researcher in the focus group session planning. The questions were shared with the participants prior to the session in order to reduce any pre-session anxiety and re-victimisation, ensuring the emotional safety of participants, plan debrief or counselling and minimise risk to participants.

The recruitment design was based on the researcher's cultural and IPV understanding of the complexities involved. A clear understanding of IPV, its impact and complexity, safety implications for survivors and their children, was critical to this study. Research practices were inclusive and grounded in community-based collaboration. These research practices were complemented by an understanding of South Asian socio-cultural values and beliefs. The deep-rooted patriarchal and familial practices are central to the establishment of trust to guide the process between the survivors and the researcher. Acknowledging the decision-making factors helped the researcher understand and respect the decisions survivors made prior and during the recruitment and data collection phase of the study, and guided understanding of the cultural sensitivities that were required.

### 3.9.4. Data collection

As a safety and confidentiality measure, the sessions were conducted during regular office hours, at an accessible, secure site that had lockable doors to meet the needs of the participants (Mechanic & Pole,

2013). Focus groups were selected as the data collection method as they provided an appropriate, safe and comfortable environment for therapeutic support by the staff worker and fellow participants. It was recognised that sharing traumatic experiences of their IPV could be emotionally challenging. Using focus groups increased validation for the participants, its purpose and trust of the work being done and the acknowledgement of the contribution of participants (Ellsberg & Heise, 2002).

#### *A confidential and safe environment*

It was important to create a safe and trusting environment for participants by ensuring that both the researcher and the community staff recruiter were immigrant women, though the researcher is not from the subcontinent. Both had IPV knowledge and training. It has been found that there is increased participation and recruitment levels when the recruiters are from the same ethnic group, with the linguistic skills to communicate and explain the purpose of the research, and are experienced and skilled in the subject of IPV (Ahrens et al., 2011; Mechanic & Pole, 2013).

#### *Onsite interpretation*

The bilingual staff worker was able to provide interpretation during the session when participants reverted to using their first language to explain situations that were complex or highly emotional. This allowed for the accuracy and validation of what was shared by the participants.

#### *Debriefing and resources*

The ability to debrief and have bilingual staff available in case of need was pre planned. It was in place by ensuring that resources were culturally sensitive and IPV informed where possible. Information regarding resources was shared before and after the session, despite participants being familiar with the community social service organisations. Crisis line support that was available within the organisation and the provincial 24-hour crisis support number was also provided. The opportunity to debrief after the session was made available for all participants. It was reiterated so that survivors could contact the researcher or the co-facilitator/organisation staff in case of emotional and practical assistance after the session. It was also critical to remind participants of their ability to withdraw from the study at any point. This was a safety measure that was important.

### 3.9.5. Service Providers' Focus Group - Sampling

Participants included experienced senior staff from healthcare, policing and community social services. One focus group of these service providers was held in Vancouver (Appendix A, Organisation Permission Letter). Service providers with experience in frontline service delivery and management were invited to participate in the focus group. Participants were approached in person and provided with the Explanatory Statement (Appendix B). They signed a consent form prior to participating in the focus group. The service providers' focus group was attended by five management and senior level staff. The participants were invited based on their experience in the area of work and of IPV.

### 3.9.6. Procedure

Service providers with experience in service delivery, management and work with immigrant South Asian women were invited to participate in the focus group. The participants were invited in person to attend the focus group based on their experience in their area of work and IPV. Participants were provided with the Explanatory Statement. They signed a consent form.

The focus group discussion was audio-taped and later transcribed verbatim. The session took approximately an hour during regular working hours. Participants had the option not to answer any question they did not wish to.

### 3.9.7. Key informant interviews - Sampling and procedure

Participants were subject matter experts, who were engaged in the area of policy, government and provincial services as well as from the healthcare, policing and community social services systems. Key informants included representatives from senior management (with ten or more years of working experience) in healthcare, community social service, justice/police and policy makers.

Participants were approached in person and invited for a one hour audio-taped interview. A signed consent form was completed prior to their interview. All interviews were conducted in Vancouver except for one, which was conducted in Burnaby. Seven semi-structured key informant interviews were conducted with a total of 12 individuals and teams. There were two team interviews with one team of two members and one of five members. One key informant interview was not included in the results due to a decision made by the study team based on the interviewee request and the quality of the audio-taping.

### 3.9.8. Qualitative data analysis

#### *Preparing for data analysis*

The de-identified audio-tapes of the women's focus group sessions were transcribed by a professional transcription service, whereas, the audio-taped service providers' focus group and key informant interviews were initially transcribed using a computer-assisted program and cleaned by the researcher. The analysis of the qualitative data was guided by Braun and Clarke's (2006) thematic analysis six step approach.

Six step thematic analysis process

**Step 1: familiarisation with the data collected**

The researcher familiarised herself with the data collected as part of the process of undertaking the thematic analysis. Through examination of the data and coding of the themes, she enabled the identification of new information contained in the primary data set. Notes were included to further capture the nuances expressed by participants during data collection.

**Step 2: data coding**

The organisation of the themes under similar headings supported the creation of categories. Precise labels were used to gather important information relating to the research questions. The coding was then

undertaken to allow the codes to be gathered and this further assisted with the process to collect comparable codes.

**Step 3: identifying themes**

The familiarisation of the data, reading and re-reading of the information contained in the data sets and sorted under different codes led to the identification of themes. The coded data was arranged in relevant themes consistent with the responses of the participants and the data sets.

**Step 4: review of themes**

The themes were reviewed using a two-step process. The coded data sets were reviewed by interpreting all the organised themes to identify resulting patterns. The next step involved was refining the process by reviewing the themes and removing any duplication.

**Step 5: organising and categorising themes derived**

A thematic map of the data was refined to achieve a clear analysis. This time-consuming process supported the identification of themes and their meanings to enable the formation of appropriate and clear terms for the themes.

**Step 6: draft report**

A detailed analysis was the result of the above process. The themes and critical information was gleaned from the data to inform the formation of a clear and concise narrative. The themes were reviewed by the supervisors for final confirmation of the process and results.

### 3.9.9. Data analysis

The data analysis was undertaken separately for the qualitative and quantitative data sets. The qualitative data was analysed using thematic analysis, followed by the quantitative data analysis. The interpretation and summary of the qualitative results was followed by that of the quantitative results. The discussion involved explaining the extent to which, and in what ways, the quantitative data explains and corroborates the results of the qualitative data (Creswell & Clark, 2011).

The data from the four women's focus groups was analysed by the researcher. The generated themes and sub-themes were co-verified by the research supervisors and merged in order to increase the understanding of the IPV experiences and challenges faced by ISAW and responses that could improve healthcare and police services in BC. These challenges are informed by the reasons that prevented the women from disclosing their experiences of IPV to healthcare practitioners and seeking police protection. The analysis of the qualitative data involved the identification of themes of patterned meanings from the dataset to answer the research questions of the study. The main themes were derived from the participant experiences. They encapsulated an important element of their IPV experiences and interactions with the formal and informal support and, healthcare and police responses, and sub-themes were thereby assembled accordingly. Thematic analysis provided the flexibility in determining the themes and sub-

themes to meet the aim of the study to increase the health and safety of ISAW and in understanding the gaps facing their access or disclosing to practitioners.

## 3.10. Phase Two

### 3.10.1. Quantitative Phase – Provincial Online Survey

The provincial online survey was adapted to provide insight into the current perceptions of the frontline responders, prevalence of IPV in communities and their service delivery, to reflect the service responses by healthcare and police services. Additionally, the survey was designed to provide an understanding of promising practices to improve healthcare and police responses to ISAW experiencing IPV across the province of BC.

The survey was adapted and modified from surveys conducted by regional frontline community projects on immigrant women affected by forced marriages and honour-based violence to suit the needs of this study (MOSAIC, 2015). No relevant prior surveys of ISAW in BC were found that focused on the IPV and service delivery by healthcare and police. The researcher in consultation with the research supervisors proceeded with the adaption of the previous surveys pertaining to ISAW to design the 30-item survey appropriate for this study. Arranged marriages, in some instances, are a result of forced circumstances and the preservation of family honour have been documented in the literature as attributes of IPV among the South Asian population (Bhandari, 2018; Anitha, 2011; Kallivyalil, 2010). The online survey was only decided as an appropriate way to gather data from a larger sample of provincial community social services, lending access to multi-sites varying in size, the populations of South Asians and inclusiveness of rural and urban communities across BC.

The survey consisted of three primary sections:

1. The first section collected brief demographic data of the participants (Appendix D). In accordance with the confidentiality assured to participants, the demographic data sought was kept to a minimum, in order to keep the responses of the participants anonymous.
2. The second section related to the service needs and gaps encountered by ISAW accessing healthcare and police services
3. The third section focused on the recommendations and interventions of participants to improve the health and the safety of ISAW.

The survey only gathered demographic data in question one to understand the representation of the professional role of participants. A number of choices were provided in addition to the “other” category, allowing a participant to add their role if it was not specified in the choices provided.

The 30-item survey consisted of predominantly structured questions. Different types of survey questions were utilised in the survey (Trochim & Land, 1982). Dichotomous questions were used to gather data relating to the perception of participants, with the option of comments, including ‘not applicable’ and ‘other’. Unstructured/extended answer questions contained comments by participants, and these included

questions regarding gaps in services not included in the survey, promising good practices in healthcare responses and police responses and questions that asked participants to share information regarding responses that they were aware were not identified in the survey. Several questions required responses that allowed multiple options, permitting participants to select the applicable check boxes in a checklist. Participants also had the option to comment on alternatives that were not included in the checklist provided. Demographic questions were included in the survey to understand the age range of the population surveyed by participants in question ten which included a range of ages. Question nine covered the number of ISAW served in the last 3 years (2012 – 2015). Contingency questions were also included, where participants could explain, "if yes, what caused you to think these situations exist in your community?" and, "has your agency/service discussed the need to increase accessibility in your community?" and, "if no, what are some of the reasons for it?"

Appendix C provides the complete survey and its items (questions and Explanatory Statement), and the sections described above. The survey content validity and clarity of its questions were sought by the subject matter experts and no changes were suggested (see section 3.19 below).

### 3.10.2. Sampling

The quantitative data collection (Phase Two), according to Polit and Beck (2012), should involve as large a sample as possible, which then improves the representativeness of the population and, in this case, was the provincial responders from community social services, healthcare and police services (Teddlie & Tashakkori, 2009). The sample was considered adequate as it included all the applicable populations of interest such as, the community social services, healthcare, and police responders with a sample size of N=304. This representation was achieved as participants from all populations of interest responded to the survey. This sample supported the research objectives, while minimising sampling errors (Burns & Grove, 2009; Polit & Beck, 2012). The quantitative phase involved the online survey of provincial community social services, healthcare and police responders. This quantitative survey design allowed for a broad participation of responders, allowing for a representation of the population of different service providers (Schneider, Elliot, Lo-Biondo-Wood, & Haber, 2003).

A purposive sampling strategy was employed for the provincial online survey. It consisted of a representation of the three groups of frontline responders: healthcare providers, police and community social services, of the province of British Columbia. In keeping with the aim of the study, the perceptions of the needs of ISAW experiencing IPV, accessing healthcare and police services was sought from all three groups to assist the study in answering the research questions to improve the health and safety of ISAW. The online survey consisted of three primary sections. The first section collected brief demographic data of the participants. In accordance with the confidentiality assured to participants, the demographic data sought was kept to a minimum, in order to keep the responses of the participants anonymous. The second section gathered data relating to the service needs and gaps encountered by ISAW accessing healthcare and police services and the third section focused on the recommendations and interventions of participants to improve the health and the safety of ISAW.

The participation of community social services in the online survey was sought as this is an important component of support and advocacy for ISAW, accessing both healthcare and police services while confronting multiple vulnerabilities. The participation of community social services was perceived as an important element of Phase Two data collection.

### 3.10.3. Procedure

The online survey was emailed to three hundred and four (N=304) frontline community service providers including crisis and victim assistance and anti-violence programs, settlement programs, transition and safe houses, healthcare and police services around the province of British Columbia. The online survey was emailed to the Community Safety and Crime Prevention Division, Ministry of Justice, and forwarded to the community crisis response programs and the province-wide helpline. The British Columbia Society of Transition Houses forwarded the survey to their workers across the Province. The survey was in English.

The online survey invitation was emailed as a clickable link to service providers and frontline responders. Service providers were able to complete the survey in a mobile-friendly format or a desktop format in an attempt to increase the response rate. The survey took approximately 20 minutes to complete during regular working hours. The survey was emailed on November 21, 2016 with an initial deadline of December 21$^{st,}$ 2016. The deadline was extended to January 23$^{rd,}$ 2017 due to a low response rate. The decision to extend the deadline acknowledged the Christmas holidays in December and it being a busy time for workers. The response rate increased with the extension of the deadline.

Participant information included anonymity information and the researcher contact details. The survey was directly downloaded from the online survey platform of Qualtrics® upon the close of the data collection period.

### 3.10.4. Preparing data for analysis

The data collected from the online survey were downloaded from the online survey platform of Qualtrics® and imported as a Microsoft Excel file for data cleaning and analysis. Descriptive statistics were generated to determine the existence of gaps for ISAW seeking healthcare and police response when experiencing IPV, services provided and current and future interventions for healthcare and police response. A total of 304 online survey emails were distributed to contact persons in organisations and associations of all three groups of participants: community social services, healthcare and police services. The number of responders varied across groups. Some participants had overlapping roles, for example one responder worked as a healthcare and a victim services worker. Due to the anonymous nature of the responses it was not possible to determine how many such cases existed.

### 3.10.5. Survey data analysis

The overall response rate of Phase two of the study was 128/304 (42.1%), achieving an adequate error level of 6.6% and a 95% confidence interval (https://www.custominsight.com/articles/random-sample-calculator.asp). The response rate was considered adequate based on the representativeness of the participants from community social services, healthcare and police services, while acknowledging the timing

of the survey during festive holidays, and the nature of the work of the participants as frontline responders for a complex issue such as IPV (Polit & Beck, 2012; Teddlie & Tashakkori, 2009). There was, however, a lower response rate for healthcare practitioners than expected for professionals (Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007).

The level of measurement within the survey determined the nature of the statistical analysis and, therefore, descriptive analysis was most appropriate. The help-seeking and disclosure of IPV to healthcare and police responders was compared, in order to understand future interventions based on current situations of ISAW. The utilisation of descriptive data analysis provided results in narrative, tables and graphs to support the robust qualitative results of the focus groups and semi-structured interviews (Fallon, 2016). Data also provided descriptive analysis of perceptions of barriers faced by ISAW when accessing healthcare and police services. In addition, the descriptive analysis provided in-depth understanding and comparison of the interventions and policies that can increase the safety and health of ISAW. Any similarities and differences between the responses of healthcare and police were derived from the analysis. The responses, which included the community social services frontline workers, were representative of the ISAW who had not disclosed the IPV to healthcare practitioners, or reported to the police.

The mixed methods modified explanatory sequential design of the study, its aim, and the overall research questions relative to the qualitative results, guided the statistical data analysis decisions. The descriptive statistics were utilised for reporting the participant profile data and frequencies were calculated to describe the service provision, challenges faced by survivors and workers, in addition to the current and future recommendations to address the gaps in service delivery, and to improve response by healthcare and police services. Comparative descriptive frequencies including tables and bar charts, and brief narrative comments were utilised to report gaps and recommendations for improvements in the service delivery of healthcare and police response to ISAW. Several responses were collapsed to provide a more logical flow of the participant responses. The descriptive analysis of the commonalities and differences in participant perceptions and recommendations assisted the process for understanding the health and safety of ISAW in BC.

Consultation with an expert statistician and the research supervisors, guided the decision for the utilisation of only descriptive analyses to understand the relationships and differences in responses (e.g. current organisation response to IPV of ISAW, organisational policies). In addition, it made it possible to draw associations between recommendations for police and healthcare interventions. Hence, thematic analysis of the quantitative data was employed to categorise the themes and sub-themes with regard to open-ended survey questions.

## 3.11. Data integration

Data integration is fundamental to mixed methods research. As part of the integration process, the qualitative and quantitative data results are derived by analysis, using clear methods providing a complete understanding of the study and inform conclusions and recommendations. Integration allows the research

questions to be answered, as informed by the data gathered (Creswell & Clark, 2011). It is the merging and mixing processes of the results that allows the different data sources to be integrated into one study (Creswell & Clark, 2011). It is in understanding the merging and mixing process that is important to this integration process. The merging implies the exploration of the similarities and contradictory data results derived from the data methods used, while the mixing is indicative of the timing and the process of mixing the data that are brought together. It is this process of integration that enhances the research results and its value (Fetters, Curry & Creswell, 2013).

When and how integration takes place can vary. It can happen at four different stages of the data design, collection, analysis and interpretation (Creswell & Clark, 2011).

In this study, the analyses of the qualitative and quantitative data were undertaken separately using the appropriate analytical methods before 'mixing' the data. The data were merged at the interpretation or results phase of the study.

## 3.12. Data Management

Data storage and security of this study follows the Australian National Health and Medical Research Council (NHMRC, 2007) regulations, which requires the data to be retained for five years as a secured file (electronically via LabArchives), with access only to the research team. Collected data and transcripts were password protected and accessible only by the research team.

## 3.13. Data quality and content validity

The quality and validity of the data remains a continuous process of conducting research. The quality of data is often described using terms such as validity, reliability, credibility, and trustworthiness. According to Creswell (2014), different strategies are required to ensure the rigor of qualitative and quantitative data during data collection, analysis, and interpretation.

The validity of the focus group questions of the women's focus group was determined based on previous work done with immigrant women, in the area of forced marriages among South Asian women and IPV. The questions were reviewed by a number of community social service workers to determine clarity and cultural and IPV context relevance. They were also reviewed to ensure cultural and safety requirements to assists the women survivors. All questions and explanatory statements were determined to be clear.

For the quantitative data, online survey, validity and reliability was enhanced by sample selection, questionnaire design, and statistical analysis. A purposive, convenience sample was employed to recruit community social service frontline, police and healthcare workers across the province of BC, to participate in the online survey.

The following steps were taken based on Polit and Beck's (2006) guide of a content validity index and it included the six-panel expert team (Cooper et al., 2019; Almanasreh, Moles, & Chen, 2019). The online survey design and questions were emailed to subject experts and research supervisors were consulted for

individual content validity. The specific steps outlined below were taken to derive the individual content validity index (I-CVI):

Individual Content Validity Index (I-CVI)

- A priori efforts focusing on essential elements of the chart audit tool
- 6 IPV subject matter experts were emailed the online survey followed with a phone explanation and the two research supervisors were consulted in person to rate the online survey design and questions for relevance and clarity. The steps taken were:
    - Relevance – are the questions relevant to the study examining the intersection of healthcare and police response to ISAW of IPV in BC? (1= not relevant; 2 = somewhat relevant; 3 = quite relevant; 4 = highly relevant)
    - Clarity – are the questions clear? (1 = not clear; 2 = somewhat clear; 3 = quite clear; 4 = very clear)
    - Computation of the number experts giving a '3 or 4' per item divided by the number of responses. Items are normally included where the I-CVI is no lower than 0.78.

The following results were achieved:

Relevance – online survey questions bar had a CVI of greater than 0.83. Hence, 83% of the experts agreed that all the questions used by the study are relevant.

Clarity – all questions bar had a CVI greater than 0.83, indicating that 83% of the experts agreed that the questions were clear.

The results of the content validity supported the design and questions of the online survey. The focus groups and interviews questions were checked for relevance and clarity by the same subject matter experts and research supervisors.

The qualitative data from the women's focus groups, service provider's focus groups and the key informant interviews were sufficiently detailed for data collection and analysis, providing transparency and possible transferability (Prion & Adamson, 2014). Supporting each theme with the women's voices and reflecting the women's own words within the themes is indicative of the credibility and confirmability of the data. This maintains the trustworthiness of qualitative research (Guba & Lincoln, 1989). The findings of the service provider's group and, the key informants, further echoed the women's voices through the dependability and confirmability of the data. The qualitative data in the study was triangulated from the three sources. The triangulation of these data sources provided a more complete picture of the gaps and responses, improving the validity of the data (Creswell, 2014; Williamson, 2005). The data were further checked for reliability by having the transcripts checked by the researcher for errors.

## 3.14. Ethical considerations

The study received approval by Monash University Medical Human Research Ethics Committee (MUHREC) from March 15th, 2015 (HREC Reference Number: CF15/4343-2015001875 – Appendix E), and was guided by the National Health & Medical Research Council Act 1992 and the National Statement on Ethical Conduct in Human Research (National Health Research Council, 2007).

Due to Canadian reporting/disclosure requirements, the following situations were taken into consideration prior to conducting the focus groups. In situations where the study revealed information of child sexual or physical abuse, the following Canadian legal requirements were to be applied. A worker from the community organisation was present at all focus groups to address any issue according to Canadian standards of practice of mandatory reporting in case of child sexual or physical abuse.

The study had the potential of revealing child sexual abuse or physical abuse, as in the case of all studies relating to domestic violence and children. The Canadian legal requirements are clear that all cases are required to be reported. This information was included in the consent form and the explanatory statement to inform participants of such situations. The safety of children remained paramount. In British Columbia, anyone who has reason to believe that a child has been, or is likely to be, abused or neglected has a legal duty under the *Child, Family and Community Service Act* to report the matter. **Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,** Canada, guided the matter: http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/

## 3.15. Anonymity, confidentiality and protection of human rights

MUHREC guidelines were utilised to ensure the relevance of ethical issues in conducting this study. The anonymity, confidentiality and protection of human rights were central to such considerations. The women were assured of their anonymity and confidentiality of their participation and information they shared as their right (Burns & Grove, 2007; Mannell & Guta, 2018). The women were not required to write their full names on the consent forms and no other identifying information was collected. The organisation worker recruited the women and had their contact information, hence, no contact information of the women was shared with the researcher. The anonymity and confidentiality of the information collected, and its maintenance, was explained in the explanatory statements and prior to the commencement of each session. In order to maintain the confidentiality of the women, they were only referred to in the transcripts by the focus groups they participated in (Appendix E – Letter of Project Approval).

The service providers focus group participants were asked to sign the consent form prior to the commencement of each session. They were provided with the explanatory statements, which included the overview of the study, and their voluntary participation. They were assured of their anonymity and informed that pseudonyms would be used in reporting the results of the study.

Key informants were provided with explanatory statements prior to their interview sessions as well. Consent forms were signed prior to the audio-taped, semi-structured interviews. Key informants were assured of the use of pseudonyms and non-identification of their organisations.

Participants of the online provincial survey were provided with information about the confidentiality of their responses and their voluntary participation in the study.

The researcher detailed the confidentiality steps taken in the explanatory statement (Appendix B). The raw data audios and transcripts of all focus group sessions, key informant interviews and online data were only accessible to the research team. The computer data and signed consent forms were kept on a password protected computer in accordance with MUHREC guidelines.

All participants were informed that the findings of the study would be presented in the form of a thesis and at relevant conferences and, written in various journals and policy and practice publications. The information contained in the reports would not identify any individual participant or their organisation.

Another important ethical principle is the respect for participants' dignity, right to self-determination and full-disclosure (Polit & Beck, 2006). All participants were made aware of the study, potential discomfort or distress and were fully informed to make choices regarding their participation and decisions to withdraw without any consequences, making sure that the research conducted was both responsible and ethically appropriate (Mechanic & Pole, 2013). The informed consent of women and their right to participate in the study included their rights of self-determination and full disclosure, whereby all effort was made to provide sufficient information about the research through the explanatory statements and reiteration of the purpose and aim of the study, prior to commencing the sessions (Polit & Beck, 2006). The women were given an option to retain a copy of the explanatory statement and their signed consent form. No women withdrew from the session. All sessions were conducted in English. The researcher and the worker in attendance spoke Punjabi, and therefore, every effort was made to clarify any questions or information in either language as required to assist the women. In situations where the women expressed their thought in Punjabi, the worker translated their sentences into English and made sure that the women agreed with what was being translated. The researcher ensured that the translation was accurate and, every effort was made ensure accuracy, by confirming with the women during the session.

A similar process was followed with the service provider's focus group and the key informant interviews. Similarly, no service provider or key informant withdrew from the study. The completion of the online survey was an indication of implied consent.

## 3.16. Cultural considerations

Cultural considerations in this study were important due to the expectations and social norms of the ISAW. However, this understanding has not been researched thoroughly. One gap that remains is the statistical data on the prevalence of the abuse that occurs within immigrant communities in general. Researchers and statisticians have not collected such data for reasons that could further stereotype and stigmatise immigrant

communities as more violent and, hence, a negative impact on the males in the community (Thandi & Lloyd, 2011; WHO, 2013). This study employed a mixed methods approach to enable the collection and analyses of data from multiple sources to explain the results gathered.

## 3.17. Beneficence and Non-Maleficence

Recognising and acknowledging the contribution of the participant to willingly share their IPV experience within the cultural context was crucial. Survivor experiences are often based in grief, loss and isolation as they adapt and re-establish themselves. It is the responsibility of the researcher to incorporate the cultural sensitivities, and safety considerations, into the entire study from its inception, design, data collection and storage and reporting. The determination of community collaboration, mode and method of inquiry and how questions are designed, safety concerns, issues addressed and cultural experiences considered in undertaking such a study, remained critical (Ahrens, Rios-Mandel, Isas & del Carmen Lopez, 2010; Mechanic & Pole, 2013).

## 3.18. Security and privacy

The researcher approached the individual community social service organisations in the four cities where the women's focus groups took place and obtained written permission for collaboration for their participation in the study. The study acknowledged that cultural sensitivities and safety considerations are inseparable. According to Campbell et al., (2009), 50% of women did not recognise their own risk prior to being the victim of attempted homicide. The risk to the physical safety and emotional well-being of participants and the research team was an area of focus and sensitivity (Hellmuth & Leonard, 2013).

In addition, there are ethical concerns in undertaking any study of IPV due to its potential harm to survivors (Cook & Dickens, 2009; Ellsberg & Heise, 2002; Hellmuth & Leonard, 2013; Fontes, 2004; Lee & Renzetti, 1990). This required researchers to dedicate effort and diligence in conducting studies relating to the IPV experiences of survivors (Clements & Holtzworth-Munroe, 2009; Delva, 2007; Hellmuth & Leonard, 2013). Although survivors acknowledged the significance of their contribution to research, the ability to predict the risk of harm to their safety and well-being remained an important concern for the researcher (Hellmuth & Leonard, 2013; Johnson & Benight, 2003). Clear and well-designed studies are required to incorporate the safety and cultural sensitivities from the conception of the study until the dissemination of the findings, especially when working with marginalised and ethnically diverse survivor populations.

Utilising established relationships with community social services allowed collaboration with trained staff, which provided credibility and increased the trust of the participants. Well-trained staff and, a researcher with culturally sensitive and linguistic capabilities, increased the participation rate and allowed participants to share openly their sensitive and highly traumatic experiences (Ahrens et al., 2011; Ahrens et al., 2010; Bloom, Wagman, Hernandez, Yragui, Hernandez-Valdovinos, Dahlstrom & Glass, 2009; Klevens, 2007; Mechanic & Pole, 2013).

The confidentiality surrounding the participant's identity was important, and it was protected and respected in order to minimise concerns of self-stigma, safety risks, isolation, shame and honour that the women associate with themselves and their experiences (Ahrens et al., 2011; Schwartz, Hoyte, James, Conoscenti, Johnson & Liebschutz, 2010). Having a known staff worker with a similar background to the participants in the sessions improved participation and recruitment, the ability to provide interpretation on-site and ensure the safety and support in case of re-traumatisation or safety concerns (Okazaki & Sue, 1995).

According to Bent-Godley (2007), the benefits of collaborative efforts between IPV researchers and community social services pave the way for responsible and sound IPV research. Collaboration through research that is made available to service providers and the community, is known to increase the respect and credibility for the research work undertaken (Mechanic & Pole, 2013).

The following steps were taken to minimise and manage risk for women participants:

i) All focus groups took place within community organisations previously known and accessed by the women

ii) Counselling and emotional support: women were able to access counselling and emotional support through the organisation or the provincial 24/7 crisis line, prior, during or after the focus groups

iii) All focus groups took place during regular office hours

iv) The focus groups were only advertised at the organisations they had received services from. This was to ensure that their ex-spouses or relatives were not privy to the dates and times of the focus group sessions

v) A crisis worker from the community organisation was present during the focus group sessions.

According to Polit and Beck (2006), beneficence remains a fundamental ethical principle where a researcher is obligated to maximise benefits while minimising harm in the cause of conducting research. It was important for the researcher to ensure that the harm and discomfort for ISAW survivors of IPV are not perpetuated in any form, physical, emotional, social or financial, and steps were in place to ensure that ISAW survivors were not subjected to harm and discomfort (Polit & Beck, 2006).

## 3.19. Chapter summary

This chapter is an account of the study design, setting, ethical considerations, sampling, recruitment, data collection and analysis of Phase One and Phase Two. The study employed a sequential explanatory mixed methods design to answer the research questions. The selected design met the needs of the study and was effective in understanding the challenges facing ISAW in situations of IPV and the responses of healthcare and police in improving their health and safety. The two phases of the study involved the collection of qualitative data using semi-structured questions to guide the focus groups and the key

informant interviews (Phase One). In phase Two, quantitative data were collected using an online survey. All data had been analysed and subsequently integrated. Chapters 4 and 5 present the findings of the data analysis.

# Chapter 4. Qualitative Results: Women's Voices

## 4.1. Introduction

The previous chapter described the study design and methods outlining its application, the sample selection and data collection procedures. The aim of the study was to examine and understand the needs of ISAW in BC, Canada, who experienced IPV and interacted with healthcare and police services. The qualitative results of the study are presented in Chapters 4 and 5, while the quantitative data results are presented in Chapter 6. The study's Phase One, qualitative results were divided into the experiences of the ISAW women (Chapter 4) and the experiences of service providers (healthcare and police services) for ISAW and experts from the policy and management areas (Chapter 5).

This chapter presents the demographic information and findings as a descriptive account of the women's voices gathered through the focus groups and a summary of the data collection process and data analyses. The experience of IPV for ISAW is a difficult and isolating one and it is clearly reflected in the women's voices. Their journey often commenced with acknowledging their initial denial of the abuse, coming to terms with and understanding the impact of IPV, and making life-changing decisions to either stay or leave their abusive relationships. Women were confronted by a myriad of factors when faced with IPV and included challenges relating to the resource and service access and coping with responses from healthcare and police practitioners. Healthcare and police services for many ISAW was the primary point of contact, providing the potential opportunity to disclose the IPV, locate resources and services and, most importantly, minimise the risk for recurrence of injuries, health complications and, for some women, avoiding death through homicides.

### 4.1.1. Participant summaries

All four regional ISAW women's focus group participants (N=22) had experienced intimate partner violence (IPV) in their relationships and accessed healthcare and/or police services while navigating their journey to a violence-free life. The four focus group locations in four different cities across BC provided the diverse experiences of women and their interactions with the healthcare and police services. Detailed demographic information such as their name, age, years in Canada or living in a particular community was not collected from the women to keep their identity confidential. Participant focus group identifier numbers, based on the focus group site, were used for each focus group participant to further preserve their confidentiality. Each focus group site was assigned a group identifier instead of identifying the participants and the location of the focus groups to further preserve their confidentiality, as shown in Table 4.1.

**Table 4.1: Participant profiles**

| Group identifier | N=22 | Date |
|---|---|---|
| FG1 | n=5 | June 16, 2016 |
| FG2 | n=11 | May 25, 2016 |
| FG3 | n=4 | July 19, 2016 |
| FG4 | n=2 | May 19, 2016 |

### 4.1.2. ISAW voices – themes and sub-themes

The data from the four women's focus groups were initially analysed by the student researcher and co-verified by the supervisors on the team. The findings generated two main themes and nine sub-themes were merged in order to increase the understanding of the IPV experiences and challenges faced by ISAW and the responses that identified how healthcare and police services in BC could be improved. These challenges are informed by the reasons that prevented the women from disclosing their experiences of IPV to healthcare practitioners and seeking police protection. The main themes were derived from the participant experiences and encapsulated an important element of their IPV experiences and interactions with the formal and informal support, and healthcare and police responses. Sub-themes were thereby assembled accordingly. Thematic analysis provided the flexibility in determining the themes and sub-themes to meet the aim of the study and to aid understanding of the gaps in service, their access to services or disclosure to practitioners (Braun & Clarke 2006, 2018). The ISAW voices are categorised into themes and sub-themes.

The two main themes that emerged from the ISAW focus group data were:

1. Understanding IPV by the ISAW
2. Disclosure and Help-seeking

The two main themes and the corresponding sub-themes are illustrated in diagram 4.1, outlining the gaps, challenges and supportive interventions as informed by the ISAW.

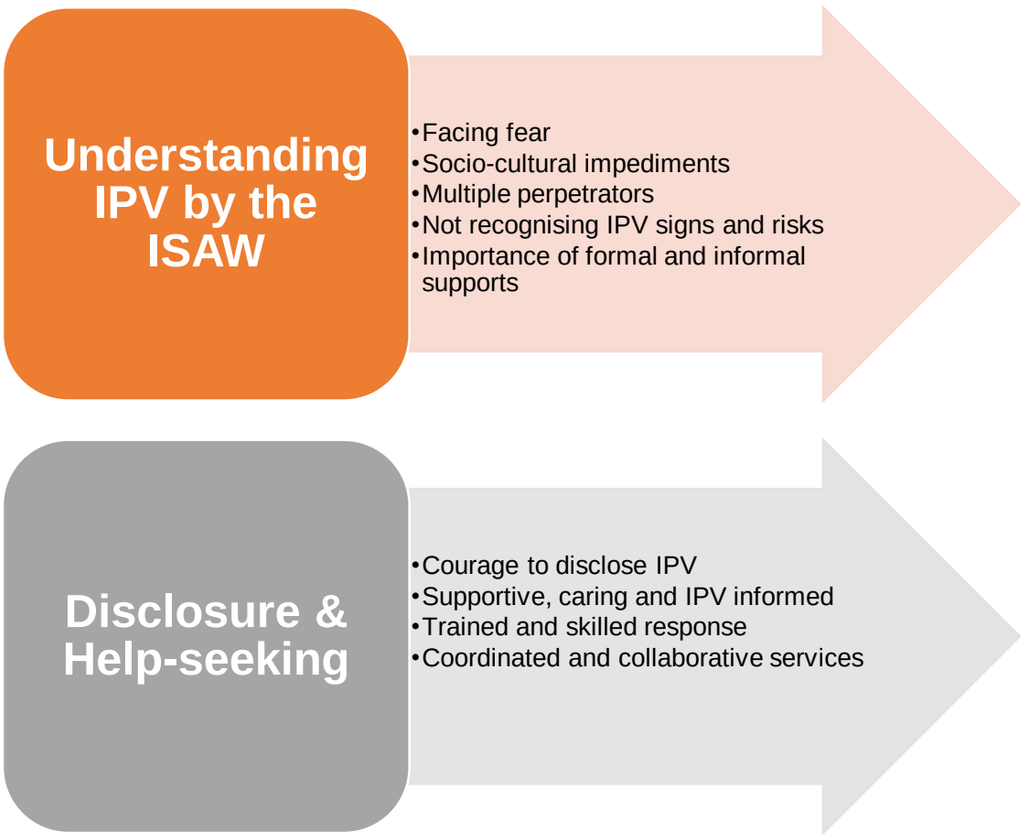



**Figure 4.1: Themes and sub-themes of women's focus groups**

## 4.2. Understanding IPV

Data that underpinned this core theme identified that the serious short-term and long-term health and safety impact of IPV was rarely comprehended by ISAW. Women admitted that it took them considerable time to understand what constituted IPV or its life-threatening effects. Women suffered severe health injuries such as burns, strangulations, physical and sexual assaults, strokes and heart attacks as a result of IPV. These injuries and assaults lead to numerous medical and police interventions prior to decisions to leave their relationships. Several factors influenced the increased vulnerability of immigrant women and their decisions to seek help or disclose to practitioners when confronted with IPV situations. Understanding the various forms of violence shortly after marrying their spouses, coupled with the innumerable complex familial and socio-cultural factors, influenced their decisions of staying in these highly abusive relationships for lengthy durations of time. Marriage and migration for many ISAW also meant leaving their homeland, family and support systems, as well as the familiarity of their rights, which played a critical role in their health and safety.

Complications affecting women's decisions and choices to leave or stay in such abusive situations were framed by them as facing the unknown or what lay ahead for them and their children. They confronted a multitude of gaps in the services and faced numerous personal challenges after they disclosed or accessed health and safety services. These complexities included facing their fears, dealing with family structures and dynamics, defying cultural and social norms, tackling their sense of physical and financial insecurity and considerations, confronting their inability to communicate fluently in English, encountering shame, stigma, humiliation and isolation. Systemic barriers, on the other hand, were heightened by their lack of

knowledge of their rights, lack of understanding or knowledge of Canadian laws and availability of resources, and the implications their decisions had on their immigration status.

### 4.2.1. Facing fear

The manifestation and prevalence of various fears in their lives, influenced the women's decisions and their ability to leave abusive relationships or seek help. ISAW explained how these fears kept them silent for prolonged periods of time in these highly abusive, unhealthy and dangerous situations. Women repeatedly shared the almost paralysing accounts of fear, and described it as, *"the fear, feeling totally insecure" (FG4).*

The fear was experienced in multiple ways and women stated that it influenced their sense of security in their new relationships and in their new homeland. The recurrence and severity of the violence, the threats to their safety, that of their children and their families, and the fear of the unknown also magnified their sense of security. There was fear of the threats and danger posed to their children's safety and that of their own parents, of which women reiterated as:

> *the fear and the safety of my children … he abuses my parents as well (FG4).*

The recurrence and severity of violence and psychological abuse were other fear dimensions women faced when they considered disclosure or sought help. There were fears of a breach of confidentiality by healthcare or police responders from their community. It prevented them from disclosing to healthcare practitioners, during often multiple visits to receive medical assistance for the injuries they sustained as a result of the violence they experienced. Hence, the threat of recurring and severe episodes of violence was a serious fear consideration for the women if their spouse learned about the involvement of the police or healthcare system. One woman described the threat by her ex-spouse as:

> *I will come back and show you what I can do. You know that kind of a threat. That's another fear. Now god knows what he'll do (FG4).*

The anticipation of the verbal and psychological abuse was stated by other women as:

> *There is always going to be verbal abusing. (FG4).*
>
> *Fears are created that anything can happen (FG1).*

The fear of a breach of confidentiality by healthcare or police responders or community members as:

> *There's just a big fear in our system or in our community. We can't share because we are always [*thinking*] at the back of our mind, if that leaks, it's going to come back again...and then he's going to do the same thing (FG4).*

ISAW who emigrated from India expressed their fears of seeking help from the police based on their prior experiences and perceptions of police in their homeland. Past experiences, lack of information and understanding of Canadian laws, and of what could happen to them and/or their children, was articulated by women as:

> *Coming from India, you have this image of the police in India and fear of police, and then you get here and you have that fear as well. You haven't seen the police, you don't know what they do.*

*Then even if a Punjabi (South Asian) police officer attends, there's always…- don't tell the police, because once you tell the police, you have to go to court and matters get worse (FG2).*

Their fears were heightened by their lack of understanding of what systemic supports were available in situations of IPV and therefore women expressed their lack of awareness of *"what is a system, what is available?"* (*FG1)* and how it contributed to their fears of the unknown. Women spoke of not knowing what to do next, and explained it as contributing to their lack of courage to seek help:

*I was totally confused. I did not know what step to take. I thought I should ask help from the family members, the friends. But I didn't have courage to speak up (FG4).*

The fear of financial insecurity and dependence on their spouses to fulfil the needs of their children was another reason why ISAW continued to stay in their relationships. Women admitted that in some circumstances the financial insecurity and the thought of providing for their children on their own even compelled them to 'beg' police officers to release their partners. By doing so women increased their risk of recurrence of violence in many cases. The financial difficulties they and their children could face deterred other women as well, as they explained:

*When I [*received*] a financial threat, I didn't see myself sitting on the street, but the first thing was my kids. That fear made me beg the cops - saying that please leave him (FG4).*

However, women who were employed were nevertheless no less emotional and financially vulnerable to the control of their spouses and it was conveyed in the following manner:

*Even if I am earning, he has access to my money. It's huge…an Indian woman, she sacrifices everything of her life, pays the most attention to serve her husband and kids. (FG4).*

The fear of bearing the responsibility of straining relationships between both the families (parents and in-laws) is another consideration prohibiting women from disclosing IPV and seeking help. Their relationships are a part of their informal social and emotional support. Struggles between families contributed to the discontinuation of support and fostered isolation as women concurred and summarised it as:

*In the beginning I never told anybody as well. There was that fear that I didn't want to tell. I felt that if I disclosed to them, that would create more problems and that the families will not talk (FG1).*

### 4.2.2. Socio-cultural impediments

The cultural and social values of ISAW are distinctly reflected in the perceptions and the voices of the women. It is evident that patriarchal and strong family values impacted the decisions women made. Values such as discussing family issues outside the family, or having self-determination or speaking up for oneself, were often considered disrespectful and an insult to one's upbringing. Women expressed it as "*we are taught from a young age that you don't discuss your family issues outside of the home" (FG2).* Women stated that the socio-cultural values and beliefs of South Asian women are fundamentally based on the cultural and religious practices of the Indian subcontinent. These values and beliefs made it difficult for them to comprehend the signs of violence, leave abusive relationships or disclose any information relating to it.

Family-centred decision-making practices are essential to social, cultural and religious values and beliefs influencing extended family dynamics. The women clarified their fundamental role as being responsible for upholding their family honour, and therefore taking on the duty of an obedient daughter, wife and mother. These roles and expectations were even more pronounced after marriage and in situations where they co-habited with their in-laws. These values and beliefs contributed to numerous impediments for women in complex situations of IPV, impacting their decisions to seek help or disclose IPV to health and law enforcement services. The decision to stay or leave an abusive relationship was deeply rooted in family-centred decisions and choices rather than an individual one. ISAW explained that it was an even more difficult decision for them if they had witnessed their own mothers in similar situations:

> *In India, the families we are raised in, we'd see our mums compromising for us. The same thing, when I experience the first time, I was thinking about my kids. Even though I was working, but still I'm thinking of them. Because I feel the kids, they have a right to have both parents (FG4).*

The burden of expectations and family honour is also carried by parents and, as such, one woman explained that:

> *If you are abused by your husband or in-law's family, you have no right to talk to your parents. If you talk…they're always blamed (FG3).*

The women discussed the close relationships they had with their extended families, which often included in-laws and relatives from the same village in India. Many ISAW explained that they lived with their in-laws when they married their spouse or migrated to join their spouses. Despite living with extended family members or having close relationships with them, it was still very difficult to disclose the violence to their extended families due to a number of different cultural and complicated familial dynamics. Women feared not being believed, taken advantage of, being further isolated, and blamed for not being good wives and mothers to their children and for straining relationships between families and relatives. These complex dynamics of the extended families, in addition to the shame and stigma they were concerned about, led to the increased isolation they experienced. Many of them were also geographically distanced from their own trusted support systems of family and friends, preventing them from seeking help. The deep-rooted isolation felt by women was described as follows:

> *I didn't have any family here. I didn't tell my parents because I felt they were far away and they can't really do anything (FG1).*

### 4.2.3. Multiple perpetrators

Another prominent element ISAW faced was the experience of violence by multiple perpetrators and predominantly from members of their in-law families. The multiple perpetrators included the mother-in-law, father-in-law, brother-in-law or sister-in-law and sometimes other relatives. The violence was often in addition to the IPV they endured from their spouses which, as a result, further complicated the situation for the women. Many of the women related to the common practice of new couples living with extended family members in both India and in Canada. They explained that it was common for ISAW to reside with their Canadian partner and his family upon their arrival in Canada after marriage. As a matter of fact, most

women moved in with their in-law families or extended relatives soon after their marriage – even prior to joining their partners in Canada – through the sponsorship process. Despite the financial benefits for a young couple, living with extended family members after marriage carried the added complexities of extended family dynamics, resulting in situations of multiple perpetrators. Experiencing different forms of violence from extended family members contributed to the acculturation process women were undergoing as new immigrants. The lack of knowledge of their rights, supportive network and resources hindered their ability to seek support and services to remain safe and violence free.

The multiple perpetrators also inflicted multiple forms of violence, "*the very first time after my marriage I experienced emotional abuse from my in-laws…" (FG3)* and yet for another woman her, "father-in-law also sexually abused" (*FG*4) her. Another woman experienced the violence from all members of her in-law family, "*my mother-in-law also would hit me or punch me in the face… everybody, including my brother-in-law, my husband was very physically abusive*" (*FG*3).

For one woman, who assisted her in-law family in migrating to Canada, experienced multiple forms of violence from all of them:

> *I sponsored approximately nine other individuals from my in-law's family. But all of them were extremely abusive, physically, and emotionally. (FG3).*

The existence of multiple perpetrators of violence moreover compounded the effects of the violence, making it more difficult for women to comprehend the signs of IPV or seek help.

### 4.2.4. Not recognising IPV signs and risks

Women articulated the difficulty they encountered in identifying and understanding IPV signs and its associated risks to their health and safety. The continuum of violence encompasses a multitude of violent acts whilst increasing the complexity of identifying the abuse in relationships. The establishment of women's new bonds through marriage, migrating to Canada is further complicated by the enforcement of societal and cultural tenets. Understanding the violence and what constitutes violence in a new country according to its laws is an additional impediment facing women. According to one woman, "*it takes a while, even to understand what is happening to you" (FG3).* The immediate onset of the violence is further obscured by women's erosion of self-esteem and confidence reflected by their sceptical questioning of themselves and their actions. This was echoed by the women and elaborated on by one woman, "*I thought something is wrong with me, I have done something wrong" (FG3).*

Witnessing the abuse within their home and its resultant minimisation by their mothers made it difficult for women to comprehend and recognise the IPV. In India, marital rape is still accepted within society and is not recognised within the legal system, which was a source of confusion contributing to the inability of women to comprehend the various forms of abuse. An additional factor deterring comprehension and identification of IPV was the physical and emotional restriction women faced after migrating, which heightened the isolation they faced. These highly controlling spouses and family members contributed to women tolerating and minimising the abuse.

As discussed, IPV is referred to by various names including family violence, wife abuse, domestic violence and violence against women in relationships, which complicates the understanding and identification of IPV by women when attempting to seek support services. This is evident from the women's responses and the length of time they stayed in abusive relationships. They lived their lives in fear, enduring the violence, sustaining multiple injuries resulting in short and long-term health problems and, in many instances, minimising the risks to their lives before taking any action or deciding to seek help for IPV. Understanding what was happening or what constituted IPV was confusing and emotionally distressing for many of the women and they described it this way, "*I was totally confused. I did not know what step to take" (FG3)*. They endured several incidences of violence before they admitted that it was not love, but abuse, and attempted to seek help. Women communicated that:

> *Trying to understand that the same man who loved me is looking different today, so we are trying to figure out what is going on (FG4).*

The commencement of the abuse varies for women, where for one woman the "*…emotional abuse started from a few days after marriage" (FG2).* IPV happened for all women amidst so many life changing circumstances, such as moving in with their in-laws and getting to know their spouse. It left no time for women to comprehend what was happening.

Women felt disheartened that they lived with the false hope of their spouse becoming non-abusive, "*I felt that maybe he would straighten out, he will get better" (FG1).* This was one reason why they stayed in these abusive relationships as long as they did. This was augmented by the lack or inaccessibility to formal and informal support.

Women felt that their spouses "*demoralised their sense of confidence"* (*FG4,)* such that their spouses engaged in mind-games and were manipulative. The control the abusive spouses had was stated by one woman, "*my husband had such confidence that I would not take immediate steps"* (*FG4)* to disclose the abuse. The psychological abuse in the form of controlling and manipulative behaviour made it even more arduous for women to completely understand the IPV they were subjected to. This affected their sense of confidence and ability to make decisions, even in situations when they felt something was wrong in their relationship.

Women spoke of the deep sense of isolation, being far from their parents and friends that impeded their ability to acknowledge the signs and risks of the abuse. For some women, not having relatives in the community did not help. It added to the isolation they felt, dealing with the abuse on their own and not recognising the abuse they experienced. The sense of self-blame, embarrassment and self-stigma further heightened their isolation from community and support people as they kept the abuse as a private matter, minimised it or hoped the situation would improve.

> *My parents were not here. I didn't have any family here. I didn't tell my parents, because I felt that they were far away, they can't really do anything (FG1).*

Women shared their thoughts of living an isolated life even after they left their relationships. Being alone with their children and raising them on their own without any support from their spouse or their extended family continued to be a challenge for women. This isolation contributed to their constant concern for their safety and that of their children.

The financial abuse women experience increased their spouse's manipulative behaviour. Women minimised the abuse due to their financial dependence and geographical isolation and, according to one woman, it was, "*because I was depending on him, he played mind games with me and tortured me" (FG4).*

The financial abuse existed despite women earning their own income. They did not have access to their own earnings. As one woman said, "*I did not have money" (FG2)* and she walked her children to school and had to walk to work as well.

Women were deprived of their rights, their sense of safety, finances, confidence and support, and are undermined by their abusive spouse and their extended family members. Women failed to recognise the deprivation of their basic needs, access to support, emotional and physical requirements as forms of abuse. Women were not treated with respect or dignity while expected to contribute to the finances of the household. They spoke of being treated like, "*we are their servants*" (*FG4).*

Women struggled to understand what was happening in their relationships and to them personally, and on some occasions, they were further deprived of their well-being and safety by their only supports. For one woman, when she confided in her aunt for support during an abusive episode of multiple abusers, she was subjected to blame, humiliation and accused of taking advantage of being in Canada. The abuse that could be heard over the phone was indeed minimised by her aunt:

> *In the background my aunt could hear my father-in-law, my husband, everybody was yelling at me saying that I came to Canada for free, I'm not worth anything…my aunt's response was, don't worry, they are just saying it (FG3).*

Despite living with her in-laws, another woman shared that she was deprived of their support and care because of her financial dependence on them and their expectation that family matters be kept private:

> *When you are in a situation with your in-laws, you can't tell them anything because they don't want you to be talking to anyone (FG2).*

Women revealed tolerating the abuse for a multitude of reasons while minimising the risks it carried to their health and safety. One such situation was described by a woman as, "*I had physical wounds in areas where I wasn't comfortable showing to anyone else" (FG4),* which comprised her health. Women remained unaware and underestimated the long-term impact of injuries due to IPV. The physical abuse these women were subjected to by their spouses was also life-threatening and psychologically impactful:

> *He was really aggressive, beating me up and choking me (FG3).*
>
> *When he assaulted me very badly and the report was made to police, they were shocked with what he had done to me (FG1).*

Women endured numerous incidences of violence and lived in highly abusive and dangerous situations in their own homes before leaving such IPV relationships. Decisions to leave these relationships required tremendous courage and strength.

### 4.2.5. Importance of formal and informal supports

ISAW clearly articulated the need for informal supports when they experienced IPV. Their informal supports included extended family members (in-laws), relatives, friends, work colleagues, neighbours, siblings, and parents. In cases where the ISAW did not have family members or relatives in the country, a lack of understanding of the law of the country or her own rights prolonged her abuse, thus restricting her options and impacting any decision around leaving the abusive relationship.

ISAW disclosed IPV to formal and informal supports in order to get necessary help. It is the severity of the abuse that often dictated whether or not ISAW disclosed the abuse to get medical or police protection. Women shared their experiences of disclosing and getting help from both formal and informal supports including nurses in triage, family members, friends and neighbors. A more detailed account of disclosure and getting help involved:

> *I first spoke with, or shared with my co-worker. And my co-worker, after listening to me, gave me the contact information for a lawyer. Through the lawyer I was able to get information about a counsellor [community support worker] (FG4).*

Women further shared their experiences of their courage to disclose and create a support system as follows:

> *I was in a very emotionally abusive relationship, and the thing that made me kind of speak up about it was having a support system. I think that was very important for me to be able to take that step and not be scared (FG3).*

> *So I had contacted my family at that point. They came and got me. They said we are not leaving you in this situation. If we do, [my family said] he will kill you (FG1).*

Women described the support and information about resources they received from community social services. Many received crisis response and practical support, and many were attending support groups. Participants described this practical and emotional support as being critical to leading them to the next step of disclosing to healthcare and police services and, in fact, participating in support groups was beneficial as:

> *The group that we attended, even initially attending that group - that was a big step, not knowing what's going to happen. All these other women that are in the room - are they going to go share our story with people out there? But as time went on and we learned what's available and how it was helping, that it brought us to a higher level of understanding (FG1).*

Importantly, women confirmed that learning from each other gave them a better understanding of the abuse they survived and expressed it as:

> *I used to think I wanted to go back and try to put my family together, but having gone through the program [*Multicultural Community Support*] and understanding from other women, I feel that I've gotten a lot of support in understanding abuse better (FG1).*

While their courage and positive response from formal and informal supports made it possible for them to leave unhealthy and unsafe IPV situations, women vented their feelings of unsupportive familial and systems responses. Women spoke about how they were discouraged or blamed by extended family members when they first tried to speak up about the violence they experienced. This related to the social and cultural values of keeping the family together and hence, expecting them to work things out with their spouses. Women described their disappointing experiences of reaching out for support from their in-laws or relatives as follows:

> *I called my mother-in-law. She was in India at the time. He was really aggressive, beating me up and choking me, so I just ended up calling my mother-in-law - to tell him to calm down but then he wouldn't. So she wasn't helpful (FG4).*

In another instance, reaching out further undermined the woman's self-esteem, leading to her silence and a minimisation and denial of the IPV:

> *I called my cousin. My cousin spoke to him [my husband] and explained that this is not good, they had a talk with him. Then there was a second incident. (FG2).*
>
> *The very first time I experienced [*abuse*] I called my sister-in-law. But I didn't get any results (FG3).*

One participant expressed how she had to return to her abusive spouse because of the lack of family support and the cultural expectations of women being responsible for keeping the family together, which kept them in abusive relationships:

> *I told everybody, my family later but no one helped me and I was sent back to live with my husband (FG3).*

The lack of information regarding available community resources was a challenge that ISAW faced. Relatives were sometimes not able to assist. One participant shared that even her relatives were not aware of what options were available for her:

> *I did tell relatives before the workers, it didn't feel that they could help me much. I would still have to go back home. They didn't know what was out there for me (FG1).*

Not only was help not offered but often IPV was avoided, joked about or taken lightly:

> *Nobody helped. When they see something happening in somebody's house, people make fun of it, they joke (FG3).*

In order to disclose IPV, ISAW had to overcome several barriers. Women acknowledged their overlooking of the risks to their own health and safety. Several participants reported that the lack of knowledge of the resources for support, the inability to meet basic needs, dependence on their families and spouses and the responsibility for the protection of their children, were among the reasons that hindered disclosure or seeking help. The reasons for continuing to stay in these relationships were articulated as follows:

> *But I didn't want to break our relationship because my parents were against my marriage, so I didn't want them to think that I had made a wrong decision. I had a daughter as well and I wanted to keep us together (FG2).*

As one woman stated, reporting the abuse to the police could have led to her spouse's arrest and a criminal record. It would have resulted in the breakdown of their relationship and, as a result, she could be living alone, which would have jeopardised her immigration status, as she explained:

> *I didn't feel that the decision was of just divorcing, separating and sending him behind bars that was not the solution I was seeking (FG3).*

Seeking the help of police continued to be attributed to the socio-cultural expectations of women's responsibility to keep the family together and a breakdown of the marriage being viewed as a failure of the women, despite the IPV or the related risks it carried to her life or that of her children.

Women were disappointed by the lack of formal support from practitioners, resulting from a lack of competency, knowledge and understanding of the dynamics of IPV. Women disclosed their experiences with practitioners who were unaware of the signs and risks of IPV, the marginalities faced by ISAW and the complexities involving the continuum of violence they were subjected to. Hence, presentation of their health concerns to practitioners did not result in appropriate information, referrals, resources, and medical attention. Women were confronted with a similar situation when attempting to obtain police assistance.

As such, the initial contact with healthcare practitioners, police officers, community social services or the justice system remains critical for women. The inadequate response received by women left them feeling 'shut down', doubting themselves and staying in unendingly abusive relationships.

The risk indicators of serious injury and lethality or homicides, such as sexual assault, choking and strangulation were not readily recognised by healthcare and police responders when reported by women. The lack of trust and courage were reasons for non-disclosures to healthcare professionals. Several women described feeling unheard, not understood and discouraged when they did not receive the support and help they needed. In some instances, women were subjected to dismissive and aggressive attitudes and actions. Several women consistently shared their experiences as follows:

> *You take a lot of courage to go and open up to your doctor. But then in response, if the doctor doesn't understand you but, on the contrary, becomes very aggressive and becomes very adamant that you have to listen to what the doctor is saying, then you kind of feel unheard…Because of my doctor's response to me… I did not have the courage to go back to the same doctor (FG2).*

The accessibility to limited healthcare services were restricted or limited by healthcare support staff such as receptionists at medical clinics. Despite the limited number of language specific doctors, and the high demand for them, women faced long waiting times and questioning by receptionists to receive the medical assistance. They expressed their frustration as follows:

> *Not only the long waiting times to see the doctor, but …the medical receptionist asked too many questions. Also, at times, the medical receptionist will say, wait for a couple of days. But when you are feeling unwell, when you are sick, you want to see the doctor on that particular day (FG3).*

In some communities, doctors were more trusted than nurses, and women explained that it was their perception that doctors were more professional than nurses and, as one woman explained, in her community they had more junior nurses and as a result felt:

> *More comfortable and safe speaking to the doctors because that's their profession. If we speak to the nurses, they're from our community and it's more like a gossip type of scenario (FG2).*

On the contrary, in other communities, women were more satisfied with the cultural competency of the nurses instead of the skills displayed by doctors. This was conveyed by the following:

> *I think nurses are trained in cultural competency, but I think that doctors also need that educational aspect, so they're more aware (FG4).*

Similarly, disappointing experiences with the lack of formal support was shared by ISAW when contemplating or reporting to the police. The response by an officer was just as critical to help-seeking by IPV survivors, and one woman explained her experience as follows:

> *When the police come to take a statement and you have just taken the courage to talk about your abuse. The police needs to be sensitive in giving you some time to even bring yourself up to giving a statement. Because you are under that continuous stress, that whatever you say, and if you defer from your statement later, that it will come around to bite you. So there is that immense pressure on you and the police needs to be sensitive that they need to give time for the victim to kind of first calm down, to relax (FG2).*

There is a cultural gap and lack of understanding of the impact of IPV on women, and one woman shared how she has heard the same comments repeatedly over the years from justice system responders:

> *This is exactly what they say, why don't they leave, why don't we leave? What is there? Just pack your bag and go (FG3).*

Having culturally competent police responders with the capacity to understand a South Asian language made a huge difference. Spouses continued to take advantage of the fact that the attending police officer did not speak or understand the language. Consequently, the spouses threatened the women and misinformed them of what will happen to them and how the system will not assist them or their children. In one such situation, a woman explained how her spouse did it:

> *He started threatening me in my own language that the cops are not going to help you. It is only me who is going to take care of you and if you complain about me or send me to jail or take serious steps, remember you'll be on the street begging (FG4).*

She explained how the misinformation about the justice system further confused her in the immediate aftermath of her traumatic experience. She wanted the police to remove her spouse in order to stop the abuse, yet the lack of trust of the justice system or the police prevailed:

> *You wanted the action because what is happening is not right but at the same time you're not very sure that you can trust the cops and the authorities (FG4).*

The police, in some situations, informed women of their inability to take any preventive action unless there were signs of physical violence. This hampered the support for women prior to lethal consequences and possible injuries being inflicted on them and their children. This was shared by a woman who was told by the police that:

> *If he's drunk they can't do anything about it until he physically abuses us. So that is kind of disappointing (FG4).*

Preventive and timely actions taken by the police responders assured women's sense of safety and encouraged them to seek support. Appropriate and timely measures by responders required follow-up actions as well. Women felt that removing their spouses from the scene was a supportive action and that their safety was assured by the necessary follow-up where:

> *A second piece is that they need to revisit the house and ask the woman how she is doing. So the follow up is very important (FG2).*

It was further articulated by women that:

> *Having the RCMP respond by following up afterwards ensures safety for us as women. We know that there is someone looking out for us. And for the abuser, in their minds, what they also see is the RCMP following up. So they're a safety support for the woman and also they're being held accountable for whatever is happening (FG2).*

## 4.3. Disclosure and help-seeking

ISAW reported that in situations when they did receive caring and informed formal or informal support, it encouraged and supported them to take their next step to safety by deciding to leave their abusive relationships. It is important also to note that women did not focus on their health or safety risks of staying in the relationship until they had sensitive and caring support in place.

### 4.3.1. Courage to disclose IPV

Disclosing IPV and reaching out for help required tremendous courage which the women identified as an eminent determinant for seeking support and help. ISAW reported that it took courage for them to challenge the multiple fears they had to confront when considering disclosing IPV. Women unanimously concurred that "*we require a lot of courage to seek help" (FG4)* and that it was done over a period of time as, *"eventually with time, over time, I had the courage" (FG4).* In order to understand it, women collectively agreed with the statement that, *"I didn't have courage to speak up. It was a challenge, I was embarrassed" (FG3).*

Their courage had to succumb to even more disturbing concepts of self-blame and guilt that the women spoke of:

> *I thought something is wrong with me, I have done something wrong. So I was blaming myself a lot (FG3).*

Another hurdle women had to overcome was the concern that disclosing the IPV to their in-laws or relatives could result in further isolation or disadvantage for them as one woman described it as:

> *I think the worst thing is when we seek any help from our in-laws, because then they know that something is happening in the relationship and then they take advantage of that (FG4).*

Women were confronted with negative consequences when they gathered the courage to disclose or seek help. They described the responses they received or consequences they encountered as a lack of support from in-laws or other relatives and often resulted in women experiencing self-doubt, embarrassment, self-

blame and sometimes even more abuse from their spouse or extended family members. This was the situation for one woman:

> *When I was experiencing all different forms of abuse, I took the courage to share it with my father-in-law and also with a family aunt. But neither one of them understood me or provided me any support (FG4).*

Also, at times, disclosing to relatives resulted in extended family members being just as abusive and humiliating. Women were motivated to disclose the abuse and seek protection services to protect their children, and this was described as:

> *Protection for my kids – that was my motivation to say it (FG4).*

Gathering the courage to disclose or seek help resulted in women taking varying amounts of time to do so. Only one woman reported going to the hospital after the first incidence of violence and disclosing the incidence, "*it was the first time something like this happened to me in my family, I went to the hospital. The hospital helped me*" *(FG1)*. Yet for other women, "*it wasn't the first time, it was ongoing and then I decided that it's time to end this" (FG2)*. For the rest of the women, it took them an extended period of time to disclose the violence, and this varied anywhere from six months to five years.

### 4.3.2. Supportive, caring and IPV- informed

Having appropriate support and referrals to resources such as justice and community social services are important. One participant articulated this need as follows:

> *My doctor provided me with a women's shelter program and then he told me if I really have to, I can inform them and get out from the house. And if I don't have any family help, he can arrange to find a social worker. And if I needed anything written from him, he can help me and give me all the different numbers so I can call for help (FG4).*

The confidentiality of the woman's identity remains critical for the safety of women. It needs to be protected and respected in order to minimise concerns of self-stigma, safety risks, isolation, and shame and honour that the women associate with themselves and their experiences. Women reported that trusting the doctor and being assured of confidentiality was important to them:

> *If I tell the doctor, he/she know the family, and they will just get mad. And will ask why did you tell the doctor? (FG2).*

Hence, it is important, women reported, for practitioners to understand the family structures and dynamics, "*it's not black and white, you can't just say, she should just leave, it's not how it works. A lot of dynamics involved" (FG3)*. Another participant went on to explain the lack of sensitivity and understanding as:

> *It goes to show, there's not a lot of sensitivity around this. There's no understanding, no one's taking the time to understand the cultural aspect of it and what we need as a community, to kind of find the proper resources and help. I think that needs to be worked on…you go in to see a doctor, they give you a victim services card or they can refer you to a psychiatrist or something (FG4).*

It was clearly pointed out by one ISAW that understanding that people are different does not require healthcare responders to focus on their culture, which will then make it easier for responders to provide support and essential services as:

> *Just the basic understanding that, it's different than how people here live. You don't even have to know the differences in the culture, you just need to understand that there are differences (FG4).*

Not understanding or taking the time to look into the underlying cause of a woman's multiple visits to see the doctor often resulted in prescriptions for anti-depressants, instead of referring women for counselling services where they could receive the emotional or psychological support they require. This concern was articulated as follows:

> *A lot of the times where I've seen patients coming in, or South Asian women who are coming in with either instances of mental and physical abuse, most of the time doctors will just prescribe them either anti-depressants or anti-psych medications, and not really give them any type of other support that they need, counselling. Once in a while we'll get a doctor - maybe after the tenth time that they come in and they'll refer you to a psychiatrist or something. Like initially it's always take these pills, it'll make you feel better (FG3).*

When women were asked about what interventions by practitioners encouraged them to seek help, they clearly articulated the importance of support and encouragement as essential to disclosing safely and in a timely manner. Appropriate and informed response by practitioners minimised the abuse and provided options for women to explore their choices prior to decision-making. Hence, supportive and trained doctors:

> *Should be able to encourage them to speak. The doctor should be able to push a little bit more and ask more, even if the ladies won't tell. They should be able to do more. They should be able to probe with more questions (FG1).*

The supportive and caring response of healthcare practitioners and their ability to recognise IPV would encourage women to disclose their abuse. ISAW felt that it was important for healthcare practitioners to continue asking about how they sustained their injuries instead of only treating the injuries:

> *Ask more questions and more questions then - she might get ready to talk. So if the hospital sees there are more signs, more signs of abuse and the doctor, the hospital and the health practitioners ask the questions, then the women might be more willing to become more open. Because they know what kind of injury that is (FG2).*

Often the doctor is the first person that women disclose to and, thus, it is important that they are well-informed about formal support. Women who do not disclose after the first incidence of violence need to feel supported and encouraged because:

> *The very first time we experience violence, we see a doctor. Maybe it's the first time, the second time, third time, whenever. You don't call police the very first time or second time when you get hurt. The first person you see is your doctor. When you go to your doctor, he should have some referrals with him…we can't afford that time because we are in that position, we are not working, we don't have money. Then she should give some referrals so that she can guide…to find the resources while you are in this trauma, and they'll find resources for you to get income (FG3).*

### 4.3.3. Trained and skilled response

Women described that they felt supported when their courage to reach out for police protection and disclosure to healthcare practitioners was met with a practitioner response that was IPV-informed and culturally skilled. These were reported as follows:

> *Then there was a second incident. At that point, I did call the police and the police helped me a lot. So for me, it was the workers that helped me a lot (FG1).*

Alternatively, participants stated that the negative attitudes of healthcare practitioners such as racism, lack of understanding of IPV and stereotyping of women, made it more difficult for them to seek help and described their experiences as follows:

> *I just want to speak about the racism a little…The skin colour, I think it's where the white skin is number one… Accordingly we are being treated…sometimes we enter a doctor's clinic in our Indian dress, and you know the reaction...that you see it in their eyes, doesn't make us feel at home. If you are not modern, you are not smart (FG1).*

Additionally, it was reported that the attitudes of doctors and their lack of understanding of IPV dynamics, stereotypical and cultural vulnerabilities can result in negative and uninformed opinions:

> *One of my doctors, she's Caucasian and she gets…a lot of immigrant South Asian women but there's also just South Asian women who are raised here from an early age or were born here. She gets a lot of instances where they come in saying that they're in an abusive relationship or situation…she's had so many of them over the years. She came up to me and said, I just don't understand why these women just don't eff-ing leave. She said it's just so stupid how they just stay in the abusive relationships (FG2).*

Not only did the doctors not understand the women and the effort it took them to disclose their abuse, instead the doctors became uncaring and even aggressive at times:

> *Basically the doctor kind of insinuated that all girls like you who come from India, just want to sit on benefits, on EI, (income assistance). You do not want to work…If the doctor doesn't understand you but, on the contrary, becomes very aggressive and becomes very adamant that you have to listen to what the doctor is saying, then you kind of feel unheard. It's very important for the doctors to hear you unconditionally, without any restrictions or any attachments to it (FG2).*

Several participants reported that training and education of service providers on IPV dynamics and cultural competency will improve the health and safety of ISAW and they agreed that *"it starts with education" (FG2)* and further clarified it as follows:

> *I think the medical doctors, as well as the courts and the justice system, there should be a course for them. I mean all these judges and the prosecutors can go to the conferences once or twice a year.*

This suggestion was also agreed to by other women who pointed out that this was not only the case for ISAW but common for women from other communities as well:

> *So I think they should be taught…given lectures or some kind of education…that leaving an abusive relationship it is not easy. It's not just South Asian, I think all these other women too, like the*

*Chinese and the Vietnamese - they all go through the same thing. That it's not easy to get out, even though we want to (FG2).*

### 4.3.4. Coordinated and collaborative services

Effective and efficient coordination and collaboration between healthcare, police, and community social services is required for responses to IPV. Women described their experiences as positive when practitioners had a clear understanding of the dynamics of IPV and issues of confidentiality. In addition, appropriate and timely referrals made women feel safe and supported, as several participants agreed:

*Firstly, my counsellor calmed me down and told me that - there are various rules in this country, where nobody can lay hands on you no matter what the reason is (FG3).*

Participants discussed some key areas where services can improve to meet the needs of ISAW and some of these included coordinated and collaborative services, training, and effective service response, stating:

*Doctor's need cultural competency training as well...So I think it's really important for people that work in - healthcare professionals, doctors, nurses (FG4).*

Most importantly, in situations where police officers are trained and appropriate steps are taken, women felt protected. The appropriate responses sent a clear message to an abusive spouse and provided the support the women needed:

*The Royal Columbian Mounted Police* (RCMP) *separated me and my husband for six months, which gave him an opportunity to realise there is something wrong and also made me stronger, knowing there were people there to help me (FG2).*

Similarly, women who received timely and appropriate referrals and advocacy, felt that they got the help they required and this notion was unanimously supported by several women:

*They gave me the emergency number too, if I do not feel safe…if I don't have anybody who can come over or I cannot go anywhere, I can phone them and go to a transition house. The police accompanied me and I think the next day the victim assistance worker called me and asked me how everything was? (FG4).*

On the contrary, the lack of appropriate training and insensitivity to IPV experiences of women navigating the justice system, resulted in women confronting systematic impediments, re-victimisation and psychological trauma. The health and safety implications of these situations were concerning based on the prevalence of the lack of understanding and overgeneralisation, as one participant shared:

*I would say 99.9 per cent of people in court - do not understand what we go through as a South Asian woman. Having to go through court and listen to, your father-in-law, your mother-in-law, and everybody against you. This [mainstream] culture will never, ever experience that or haven't even heard of it. This is exactly what they say - why don't we leave? What is there to it? Just pack your bag and go. (FG3).*

Similarly, it was just as difficult for women when police officers were not culturally and IPV trained. Consequently, it made disclosures and answering direct questions by the police challenging for ISAW. Instead, it would be helpful for:

*The police need to be sensitive, culturally, because they ask you direct questions and they expect a direct response. But then the way you have been socialised, at times you are apprehensive to directly disclose your experiences (FG3).*

Hence, effective and efficient coordination and collaboration between healthcare, police, and community social services requires a clear understanding of the complex and complicated IPV experiences of ISAW.

## 4.4. Chapter summary

The results reported in this chapter presented Phase One of the qualitative data of the four women's focus groups conducted in four cities across the province. An analysis of the data identified two main themes: Understanding IPV by the ISAW and Disclosure, and Help-seeking. Understanding IPV by the ISAW included sub-themes of facing fear; socio-cultural impediments; multiple perpetrators; not recognising IPV signs and risks, and the importance of formal and informal supports. Disclosure and help-seeking included subthemes of: courage to disclose IPV; supportive, caring and IPV informed; trained and skilled response and coordinated and collaborative services.

All participants agreed that facing their fears and recognising the IPV signs were barriers that hindered their ability to disclose to healthcare providers or seek help from the police. Their responses included their perceptions, experiences of IPV and knowledge of services as they had navigated their own journeys to safety. The hurdles they confronted are clearly evident from their responses of how complicated and complex their choices and decisions were when leaving IPV situations, including many health and safety risks to themselves and their children. They also clearly articulated the socio-cultural barriers they faced. These included their upbringing, family honour, and living in extended families that further complicated their ability to seek help or remain healthy and safe. The ISAW were able to build their resiliency when they received informal and/or formal support from family and friends and, most importantly, from culturally and linguistically trauma informed responders. Their need for supportive, caring and well-informed responses were central to their suggestions to improve responses for ISAW who wanted to leave IPV situations. They suggested that such culturally and linguistically trauma informed services required enhanced training, skills and capacity, together with cross-sectoral coordinated and collaborative health and police services.

The findings of this chapter provide critical understanding of the complexity and multi-layered intricacies influencing the help-seeking strategies for improving the health and safety of ISAW. A discussion of findings presented in this chapter will be provided in Chapter 7, which integrates the findings of Phases 1 and 2. Highlights of the key issues are presented relative to service delivery of IPV services to ISAW. Chapter 5 will discuss the findings of the service providers' focus group and the key informant interviews.

# Chapter 5. Qualitative Results: Service Providers

Chapter 5 provides the results of both the service providers' focus group and the key informant interviews conducted with the policy makers, policy analysts and management professionals. The findings of the chapter are integrated to provide a more comprehensive picture of the service delivery and response to IPV of ISAW.

As previously indicated, the study's Phase One qualitative results were divided into the experiences of the ISAW women (Chapter 4) and the experiences of service providers (healthcare and police services) for ISAW and experts from the policy and management areas (Chapter 5).

The reported data are categorised under themes and sub-themes. Participant responses provide information that relates to service delivery challenges and effective prevention and intervention strategies. This identification of challenges and service delivery responses are significant in contributing to the increased health and safety of ISAW. These results provide a perspective pertinent to the health and safety of ISAW, employing a macro lens view of systems and the role of government.

## 5.1. Phase One – Service Providers' Focus Group & key informant interviews

### 5.1.1. Overview of Focus Group

The service providers' focus group was held on December 1, 2016 in Vancouver, British Columbia. The service provider's focus group was approximately one hour and the session was audio-taped. The participants are described in detail in Chapter 3 as part of Phase One of the study's data collection.

A total of five female participants attended the focus group and pseudonyms are used to preserve their anonymity. The service providers were professionals with extensive experience in service delivery in the area of IPV.

### 5.1.2. Profiles of the service providers – Focus group participants

The focus group participants were selected based on their work experience and role in management and service delivery. The group included a registered nurse, transition house manager and front-line staff member, a senior counsellor/case manager and a past police victim services volunteer in a rural community. The participants worked with women across a variety of geographical locations in British Columbia. The participants were identified with pseudonyms in order to maintain their anonymity. A breakdown of the participants, their profession and their length of service in the area of IPV is outlined in Table 5.1.

**Table 5.1: Service providers' focus group participant profile**

| Profession | Pseudonym | Length of service |
|---|---|---|
| Registered Nurse | Lin | 10 years + |
| Transition House manager | Preet | 10 years + |
| Transition House staff | Priya | 5 years |
| Senior counsellor/case manager | Leena | 10 years + |
| Rural community victim services/community communications | Pam | 5 years + |

### 5.1.3. Overview of the key informant interviews

Individual interviews took place between August and December 1, 2016 in Vancouver, British Columbia, at the offices of key informants during regular office hours. The interviews were approximately one hour and were audio-taped. The sample is described in Chapter 3 as part of Phase One.

The twelve participants were selected based on their work experience and role in policy, practice, government in healthcare, community social services and police services. The participants worked across a variety of geographical locations in British Columbia. The participants were identified with pseudonyms in order to maintain their confidentiality.

### 5.1.4. Profiles of the service providers: Key informants

Twelve semi-structured key informant interviews were conducted with individuals and teams of policy, government and provincial representatives working in the area of violence against women from community social services, healthcare and policing systems. The interviewees were primarily policy analysts, policy makers and subject matter experts in services to survivors of IPV within the three main services the study focuses on. There was one participant whose work specifically focused on services to multicultural communities, including ISAW. The other participants were representative of a diverse demographic, had long-standing service in policy and practice backgrounds and were experienced in a variety of areas. All participants brought a depth of knowledge rich with their understanding of the issues and intersections affecting women experiencing IPV, including ISAW. Some of the intersections included: work with children, mental health, youth, Aboriginal communities, frontline victim services, counselling, housing, health and policing. The key informants were identified with pseudonyms in order to maintain their anonymity. Table 5.2. is a detailed account of service providers gender, pseudonyms, profession and length of service.

**Table 5.2: Key informant profile**

| Profession | Pseudonym | Length of service | Gender |
|---|---|---|---|
| Executive Director | Simi | 20 years + | Female |
| Executive Director | Penny | 20 years + | Female |
| Director, System & Service | Tom | 20 years + | Male |
| Senior Policy & Legal Analyst | Anne | 10 years + | Female |
| Senior Policy and Legislation Analyst | Terry | 10 years + | Male |
| Senior Analyst | Tim | 10 years + | Male |
| Royal Canadian Mounted Police (RCMP) | Belle | 20 years + | Female |
| RCMP | Sarah | 10 years + | Female |
| Manager, Health | Sherry | 10 years + | Female |
| Health | Karen | 10 years | Female |
| Manager, Aboriginal Coordination | Lisa | 5 years | Female |
| Youth Coordinator | Alice | 5 years | Female |

### 5.1.5. Themes and sub-themes

The findings of the interviews with the service providers are categorised into themes and sub-themes. These themes and sub-themes are presented in Table 5.3. The four main themes that emerged from the service providers' data were:

1. Service responses
2. Gaps in service delivery
3. Systemic barriers
4. Supportive interventions

The four themes and the corresponding sub-themes are illustrated in diagram 5.1., outlining the gaps, challenges and supportive interventions as informed by the service providers.

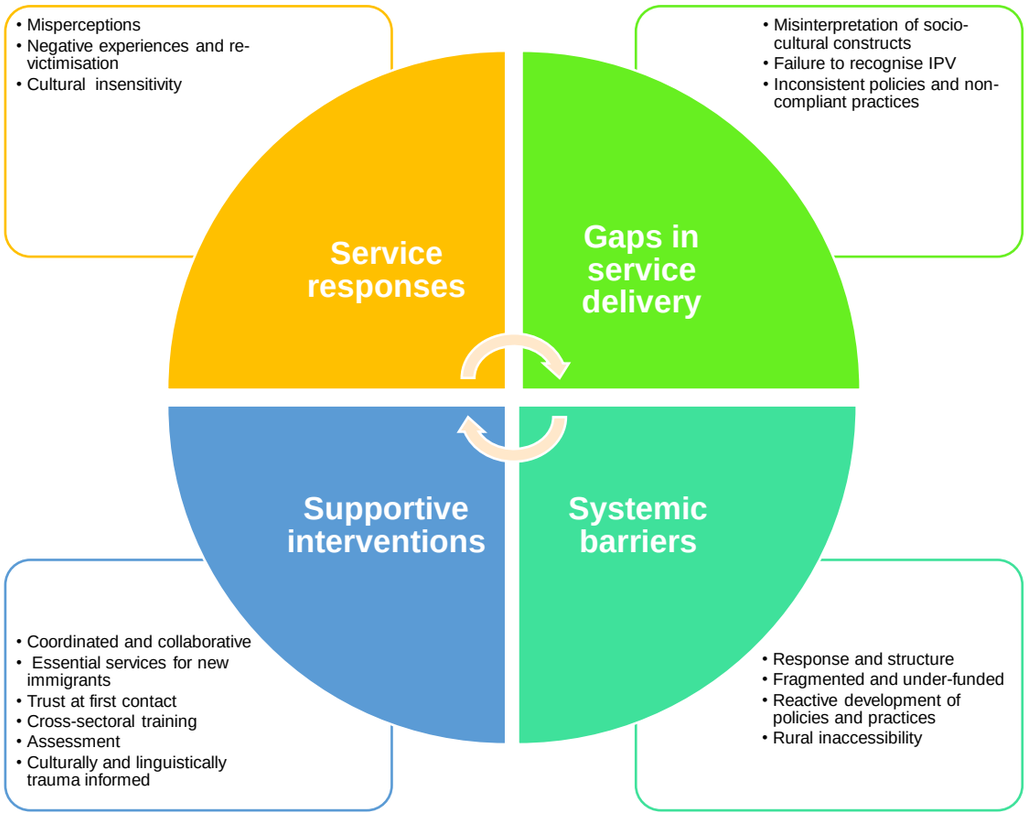



**Figure 5.1: Themes and sub-themes of service providers' and key informant interviews**

## 5.2. Service responses

The structure of systems, response of services and government policies and practices are fundamental factors that participants agreed were responsible for ISAW feeling silenced when contemplating disclosing IPV to healthcare practitioners or reporting IPV to police. To a large extent, the results denoted that the structural makeup of the healthcare and police systems influenced responses and shaped current interventions, policies and practices in British Columbia. Yet, it is of utmost importance to understand the barriers preventing help seeking to minimise injuries and reduce the risk of violence.

### 5.2.1. Misperceptions of responders

The misperceptions of responders, the fragmentation of services, the lack of accessibility, and a system that is known to respond only, "*when women die*" *(Leena),* was described by participants as the current state of healthcare and police service delivery. Participants acknowledged the existence of improvements in responses, such as the Provincial Violence Against Women in Relationships policy and efforts within individual communities and organisations, but these interventions had a, "*long way to go*" (*Leena*), with regard to ISAW as the efforts made overall in the area of IPV does not support the notion of, "*one size does not fit all" (Leena).*

Participants were asked about how healthcare professionals and police perceive ISAW. Participants were disappointed that the perceptions of responders retained stereotypical notions of ISAW. They were perceived as passive and indecisive when it concerned seeking police protection for IPV. Decisions not to

proceed with pressing charges for IPV or continue staying in the abusive relationship, are viewed as a waste of police time and effort. One participant reported that a police officer described ISAW as:

> *Poor women, silenced women. She has been controlled. She's not going to leave him … we might put charges but then she's going to work with him. They say … 'we'll do it, but I'm telling you, she's going to change her statement' (Leena).*

This misperception of ISAW was further confirmed by several other participants. When asked if current interventions and services offered by healthcare and police services are sufficient, there was strong agreement among all participants, "*there's a long road to go …" (Preet).* Participants agreed that, on the contrary, *"there should be more"* (Preet), done to increase the health and safety of ISAW.

There was consensus among participants signifying the bias and stereotypical perceptions of the responders in both systems. Generally, ISAW were being perceived as submissive or suppressed, which compromised the service delivery based on women's ethnicity or vulnerability.

The concept of perceiving ISAW and, in fact, all women as passive, results in them being blamed for their experience of IPV. This was elaborated as:

> *Culturally when it comes to domestic violence and women in general, there is this perception or this perspective that the woman needs to do something. She needs to protect the children. She needs to change, she needs to do something different … and I mean historically when we've ever approached any sort of issue of whether it's, rape, sexual assault or any sort of issue in which women are predominantly the victims of our cultural intervention. It is always the woman needs to be doing something different and it's not necessarily explicit, but implicitly what that says is you're currently doing something wrong. If you only did it the other way (Sherry).*

An example shared by Pam depicted a further victimisation of ISAW by inappropriate responses from the police:

> *My partner was a Caucasian, and the way he's dealing with it, you can see it playing out. You know, he is not getting it, he doesn't have the language, but he's also not getting the cultural nuances and the family dynamics. And the in-laws are there and … it just plays out so horribly.*

### 5.2.2. Negative experiences and re-victimisation

Negative experiences from police or healthcare professionals deters women from disclosing or reporting IPV. For example, a woman who has had a really bad experience when she called the police herself or who has heard of a bad experience, will be deterred from seeking police services for safety or protection when faced with IPV. Consequently, it is imperative for responders to be both trauma informed and culturally sensitive when responding to IPV.

Consequently, participants expressed that ISAW take several factors into account prior to disclosing or reporting IPV. Although in the case of health care, they have the choice not to disclose, it is more difficult for them to do so when police are called to an IPV scene. Such situations arise when either a neighbour, abuser, or his family calls for police response. Under some circumstances, due to the non-application of the Violence Against Women in Relationships policy (VAWIR), the police may arrest the woman due to the corroborative account of the abuser or his family. In some cases, dual arrests could be the result for both

the woman and her abusive spouse, due to the lack of sufficient evidence at the scene and inexperience and training of the police in IPV dynamics and identification.

In addition to language skills, it is essential that responders understand IPV dynamics and are culturally sensitive and competent. Not understanding cultural nuances or directly translating the spoken language can deter women from disclosing or seeking police protection in life-threatening situations, based on their own experience or those of other women. One such situation described by participants involved the lack of language proficiency or literal translation of the language by service providers, resulting in grave consequences for ISAW survivors. One particular case involved the literal translation of the Punjabi language by the officer. It resulted in misinterpretation, and a lack of consideration for the cultural context of the IPV dynamics. The situation had serious implications and traumatised the woman and her children (one of whom was a one-month old baby). The following scenario was shared by Preet:

> *Something happened at home, the police came, and (one officer), he said to the woman, 'please take your kids and go inside, to just separate them '*
>
> *However, the woman replied in Punjabi, 'I will stay "barh" ', meaning – she will remain in the living room, instead of the literal translation of "barh" as outside. This was mistranslated by the Punjabi-speaking police officer as the woman requesting to leave her home and take the kids with her. As a result, they [Ministry of Child Protection] apprehended the children and arrested her while her one-month old baby that she's breastfeeding was left at home… She stayed in the inner cell that night. This woman has probably never stayed anywhere else. Just imagine, when you're nursing, what's going on in her body. The dad's calling, the baby's crying and they took her to the hospital. She's going through some postpartum. But then again, that is such a crucial piece about the misinterpretation… It is very important that they should understand the cultural context.*

This situation of mistranslation was finally resolved with the help of the transition house staff, who were contacted by the police to provide culturally and linguistically appropriate support to the woman.

> *The workers from the transition house got involved and were able to support the woman. And she came … but she was so scared. So, do you think she's ever going to call the cops for what happened? (Preet).*

Similarly, participants identified response challenges being a consequence of insufficient time to respond by healthcare practitioners and the police, resulting in a selection of uncomplicated clients with less complex concerns. According to one participant:

> *Right now, both our police system and medical, are very busy. There's only limited time and even to get a directory of family doctors is so hard. As for access to GPs … what I found is they want easy clients - young, healthy. But here's someone maybe with mental health, with other multiple barriers or addiction. They just don't have time for those other people who really need that support (Preet).*

When seeking health services, one participant suggested that women visiting a doctor's office feel compelled to address one issue per visit. Hence, women feel restricted to seek relief for all their health concerns but instead, they are compelled to choose between care for their physical or their emotional symptoms. Women are told by their doctors that they have limited time per visit and in some cases as limited as, "*eight minutes per visit"* (Leena). Consequently, women suppress their abuse instead of

disclosing and getting help. There is also the challenge of the doctor prescribing medication for depression or anxiety without a clear understanding of the IPV situation the woman could be experiencing. Leena explains the situation as follows, where a woman is visiting a doctor:

> *You can only talk about one issue. So, when are we going to look at their mental health? And the woman wants to talk about her stomach pain, she's not going to be able to talk about the abuse. She will have to go back and being busy looking after kids and working full time, has to go and sit for an hour at the clinic.*

In another situation:

> *A woman facing the abuse talks to her doctor … this is what is going on in my life and the doctor says you are depressed and prescribes her the medicine. (Leena)*

### 5.2.3. Cultural insensitivity

Responding in an appropriate and timely manner requires understanding of the underlying socio-cultural realities ISAW face. The IPV dynamics, in conjunction with socio-cultural attributes, contributes to isolation, further silencing ISAW in situations of IPV. The re-victimisation the woman faces from her abusers, the systems and her community, constricts any contemplation of support by her, but instead acts as a deterrent to disclosing IPV. It contributes to tendencies of minimising the signs of risks to her health and safety and results in further isolation.

> *The support system from the family is not really there ... I think system fails first and then the community … it's so hard to start your friends circle. It's the isolation and women are labelled and ostracised by the community, by their own family. It has always been there in my experience and it continues to be. And that's further silencing (Priya).*

It is important to contextualise that the fragmented system response and the misinformation provided by abusive spouses further marginalise ISAW. The power and control dynamics of IPV has been used by abusive spouses and their families to further intimidate and misinform women, serving to heighten their fear and maintaining control over them.

> *What has happened is that the stereotypes or the myths have manifested … The controllers are the abusers. They are saying to these women, the newcomers … if you go to the police, you are the one who is going to suffer (Priya).*

Misleading information, often promoted by abusive spouses, contributes to a general lack of knowledge, especially for women who are isolated from more mainstream sources of information. This kind of isolation and misinformation is further exacerbated by a response system that is working in silos, Leena commented:

> *This is what's going to happen because we have a very fragmented system.*

The threat of deportation or immigration related information is utilised by abusers to misinform and instil fear, deterring ISAW from seeking help. ISAW tend to believe their spouses due to their patriarchal socialisation and religious values as one participant explained:

> *I think that the male population because of their privileges, they further misuse the system that's in place. I hear women say all the time … my husband told me was that - I'm only going to sponsor*

*you … on those conditions. And these women are misinformed with all the myths … So … she is basically going to believe only in what her husband has told her because that was her only contact. And again, because of our socialisation, the way we have been raised, we look up to our husbands like in our religion (Leena).*

Women often consider doctors as authority figures and therefore do not disclose IPV until they feel safe. There is an inherited misconception of the authority of professionals such as doctors and police officers. Participants agreed that interactions with professionals are missed opportunities for improving the health and safety through appropriate referrals and information relating to safety planning. One participant commented:

*There's a lot of respect … you sometimes even hesitate saying certain things because you feel … the doctor or the medical practitioners, they are on a pedestal. And to be honest, many women when I asked them, they say, I never shared it with my doctor. And that is the sad irony because we all know, that doctors is the first place for … a referral or some options to the victim. But it's not happening in reality (Preet).*

ISAW face additional barriers to safely disclosing IPV in healthcare settings, if she is accompanied by her spouse or they are seeing the same doctor. In such cases, the doctor's response to a disclosure of abuse is simply to prescribe medication for depression. Doctors and healthcare practitioners often do not have the time to ask questions, focusing only on the physical symptoms being presented. Paying attention to indicators of emotional health is also critical. This, of course, relates to the minimum time doctors and hospital staff are able to spend with patients due to busy healthcare environments. One participant identified these gaps in service delivery as follows:

*Most of these women are taken to the doctors that are of the husband or the extended family. And then the doctors don't even want to spend a little bit of extra time. (Priya).*

## 5.3. Gaps in service delivery

An exploration of the participants' experience working with ISAW within healthcare, community social services and police services identified a number of gaps in services. There was an apparent comprehension by participants that the culture, family structure and social construct implicates service delivery to ISAW.

As Preet explained:

*The gap in service is when the woman leaves and her partner changes the locks and she is not feeling safe to go alone to get access to her possessions. In one situation, the woman found herself having to incur cost to buy her personal possessions instead of being able to get her belongings from her house. She was living with us in a transition house and … had a lot of stuff at home.*

### 5.3.1. Misinterpretation of socio-cultural constructs

Understanding the dynamics that influence situations relevant to seeking help were raised by participants. As one participant emphasised, "*understanding is all that matters*" (Simi). Seeking help first from informal supports versus formal support from professionals remains clearly evident among ISAW. This was qualified by the provincial police statistics:

*The social science research is that the vast majority of victims of domestic violence are not reporting to police. It's over 80 percent and in a majority of those cases, they indicate they're relying on family and friends. So clearly there's a role here for family and friends' involvement in this … And I've seen stats around like, for example, that 90 percent of immigrant women do not report to police. So that's pretty significant, right? (Terry).*

The strong patriarchal values among ISAW add to their inclination to hold themselves responsible for keeping the family together despite the existence of IPV. Sherry confirmed this situation by adding that:

*There is an element within the Southeast Asian community … of that female complicity in male patriarchal societies … You see it in any domestic violence situation … There is still the need, the drive within women to keep the family together (Sherry).*

The pressure to keep family matters confidential due to shame and stigma remains manifested among ISAW as a result of cultural and familial values. This concern for the isolation and the lack of disclosures was explained by Anne as:

*I think my fear with this population from what I've seen is that there's, because they're isolated and there tend to be a fair amount of cultural and family pressure on them to ... maintain the cohesiveness of the family is that things don't get disclosed … They see it as a private matter (Anne).*

And a grave concern from the police perspective of family dynamics as a barrier to seeking services was:

*People don't want to leave their spouse or they can't because of family dynamics … it's just you can't … leave. You would have to be almost killed before I think you're allowed to leave (Belle).*

Another participant pointed out the importance of such understanding in service delivery as critical, and:

*Understanding the cultural context and the culture nuances … and going beyond just the knowledge of the Punjabi language, listening and speaking skills, is very important (Preet).*

The lack of cultural and family dynamics understanding in IPV situations can further comprise the safety of women, potentially increasing their risk of violence and health complications. One such situation involves extended family members and abusive spouses being present or being utilised by healthcare practitioners as translators during medical appointments:

*We know statistically and also anecdotally, that many girls and women, they start to suffer from the trauma and the abuse – the minute they land in this country … from their husband and extended family … And the doctors don't even want to spend a little bit of extra time … We have heard from women … my mother-in-law was with me … my sister-in-law was with me. My husband was with me because I don't speak the language (Leena).*

Pam further explained the reasons why ISAW do not disclose to a nurse due to the isolation they experience:

*You can't go to the nurse, can't explain what's going on … living in isolation … in small towns these women's out there, it's like the road is so long, there are so many challenges there.*

### 5.3.2. Failure to recognise IPV

In addition to understanding the socio-cultural barriers confronting ISAW, service responders should recognise the signs of IPV. Every woman should be provided with relevant IPV information, referrals and supportive resources in the community. The identification of IPV is vital to the health and safety of ISAW. It

is also essential to acknowledge that it is a woman's choice when to disclose to IPV based on her reality, her trust of the practitioner, and available supports for her and her children. Accordingly, acknowledgment of the difficulties ISAW face in making disclosures has to be understood without denying her the information she needs to disclose or get help, when she is ready. Leena explained it as follows:

> *At the beginning it should be flagged and right away some wrap around services should be given and even at the end of the day … it's the woman's choice, if she wants to or not. But at least, that should be offered. Especially for the South Asian women because they look at it as - it's my family. You just need a little bit of extra support to disclose IPV.*

Healthcare and police are often the first responders in situations of IPV and their recognition and informed response can make a difference in encouraging ISAW to disclose and seek help for IPV. Proactive responses would make an improved difference for ISAW. Participants suggested that healthcare practitioners proactively ask questions about IPV and take the time to identify the signs in such situations:

> *Medical doctors and maybe nurses can do it slightly different … their lack of education or comfort with bringing up anything to do with relationships … if the patient doesn't disclose … you can still ask questions that would lead you to the opportunity to discuss (Leena).*

### 5.3.3. Inconsistent policies and non-compliant practices

Various descriptions of provincial and system policies that are created, tend to meet the general need of IPV survivors, while the needs of ISAW continue to remain unmet by policymakers. One participant articulated this as a lack of understanding of ISAW needs because of this notion of, "*one size fits all*" (*Simi*) and, "… *a lack of understanding of the culture and that's why every now and then this severe racism issues occurs"* (Simi).

A gap in service delivery is the lack of understanding of the numerous realities confronting women in situations of IPV, as Preet explained one such situation of a woman's safety, financial difficulty and being displaced from her home and personal possessions:

> *The gap in service is when the woman leaves and her partner, changes the locks and she is not feeling safe to go alone to get access to her possessions. In one situation, the woman found herself having to incur cost to buy her personal possessions instead of being able to get her belonging from her house. She was living with us in a transition house and … already had a lot of stuff at home.*

Terry suggested that while the policies and practice guidelines in BC are, *"unique in its victim service program structure",* they do support the choices of women seeking help, *"ensuring there are no barriers for a woman who wants to leave,* but *"may not want to engage with the criminal justice system directly".* He further explained that it is not mandatory for women to report IPV, highlighting her choice and readiness in doing so:

> *We want to be respectful ... We don't want to inadvertently close off doors so she can go to a community-based agency and that agency can perhaps encourage her eventually after some support to make the report to police. But it's not a requirement … the woman has the option of not reporting (Terry).*

There are provincial policies based on the Violence against Women in Relationships Policy (VAWIR), which is a framework utilized to inform policy for victim services and police services in BC. Of significance is the referral policy for *"power-based crime services"* (Terry). On the contrary, participants pointed out non-existence of consistent practice across services with regards to the duty to report in situations where the safety of women is at risk and making appropriate referrals to services for safety planning. As such, despite the existence of provincial and healthcare policies for the duty to report, much is left to the discretion of the healthcare practitioner:

> *The legislation exists in a domestic violence situation for us to be able to disclose that information with or without consent in this province … as I said, it is vague legislation, so how that translates onto the ground, is vastly different from community to agency to health authority … it doesn't mandate you. It isn't a duty to report. It doesn't obligate you (Sherry).*

The overall opinion held by participants was, despite the existence of a provincial policy framework and policies to guide services, it does not necessarily translate into actual practice. As a consequence, practitioners' knowledge of appropriate response remains inconsistent. Nevertheless, participants agreed that while there is diversity across individual and community realities, recognition of this diversity is fundamental to service delivery:

> *Diversity of culture, of religion, of practice, of language which requires a recognition in service delivery models. And not understanding in and of itself creates an issue. So really understanding the individual circumstances sort of has to trump anything else that I say (Sherry)*.

Sherry expressed her concern for the isolation confronting women due to IPV and the resulting lack of family support as follows:

> *When you experience domestic violence or even when you're experiencing mental health or substance use, your world starts to become smaller. People pull in, isolation happens, you shut down … So if you had a social circle and a family, everything sort of naturally just gets smaller and you usually become less and less connected to family (Sherry.)*

Participants agreed that service delivery improvements are primarily achieved through policy development and implementation. Critical to impacting change is the implementation of any new policy through the provision of training to responders. However, implementing policy changes and achieving consistency in practice is challenging. Ultimately, according to the participants, what is required to accomplish a reduction in the rate of IPV-related homicides are some key elements of commitment from the government and policy makers, stable funding and sustainable services and programs. Anne clearly expressed it as:

> *There's probably a need for the government of BC to provide more robust services and provide funding for those services so that when folks do disclose and if they disclose in and they get the response, like a robust response that refers them to a program, especially folks who are marginalized and vulnerable, like refugee women, you want them to have an open door in front of them.*

With regard to effective prevention strategies, one participant expressed uncertainty:

> *I'm not sure how effective we are at the prevention of things and the public awareness with the community awareness piece, but certainly we're responding … We still have the same challenges*

*around the languages and cultural barriers. I don't think the justice system is any better prepared now than 20 years ago (Leena).*

Nonetheless, some participants were hopeful about efforts of improving trauma informed policies and practices in British Columbia:

*There is some movement around trauma informed practice out there ... Aspects of government's policy ... I think are stronger than they've ever been, but still a ways to go. So there's definitely been a lot of improvements and changes even in the last five years (Penny).*

## 5.4. Systemic barriers

Participants discussed the systemic and political barriers faced by ISAW. A number of the participants believed that the fragmented services, along with the lack of basic support resources such as affordable housing, among others, are reasons that women feel compelled to return to their abusive spouses. Participants agreed that:

*Many women because of the lack of housing, lack of affordable housing, lack of childcare, ended up going back to the abuser (Preet).*

### 5.4.1. Response and structure

There are various reasons for the gaps and barriers faced by ISAW in accessing services. The limited availability or lack of language translation aggravates the impact of, *"cultural isolation*" (Belle), and this was reiterated by Terry:

*The lack of available interpretation services ... always come up as a potential barrier in terms of ... people who newly immigrated (Terry).*

The inadequate language skills of the ISAW or those of the attending police officer compromised the health and safety of the women. In several cases, women have been arrested due to such inadequate language skills, and inexperienced police officers, leaving the women to cope with the subsequent struggles of having to clear themselves of criminal charges. Women who are arrested are often re-victimised by IPV and then by the response system. They are often not able to access support from community victim services due to their categorisation as perpetrators instead of victims. Additionally, they pay the price of losing their family and children in the process. These are very serious challenges confronting women who may choose to seek help but are incarcerated due to their language skills and competence of police response. In some situations, dual arrests results in criminal charges against both the abusive spouse and the woman. The possibility of arrests or dual arrests is a strong deterrent preventing ISAW from reporting their experience of IPV, even in lethal situations. As one participant explained:

*Another fear is the flip side for dual arrests … And that being one of the things that actually stop people from reporting … So our gap or barrier is our uniform (Belle).*

Several barriers stem from a lack of information and understanding about the roles of various responders and systems, such as the police, the legal system and the healthcare system. At the same time, barriers

can be inherent in service-delivery models, as discussed in this example regarding the culture within the healthcare system:

> *The culture around health care and the delivery of healthcare services is, we would like to deal with the individual and we want to deal with the presenting problem. You identify the problem that you have. You come to me, I'm going to fix that broken arm and I'm sending you on your way. And that's the lens through which healthcare has a tendency to focus. Really it's individual and you know it's problem specific. One problem at a time and … although intellectually and all the evidence tells us that … people live in families you need to look at holistically and you need to look at wellness (Sherry).*

Similar to barriers in healthcare culture, one participant expressed the challenges ISAW face with police culture:

> *I don't know that we're very welcoming historically and currently, something that would make a woman in this sort of situation very, very reluctant to contact the authorities … I would add concerns around risk to their immigration status (Penny).*

Reflecting on the police system, one participant raised the issue that they, "*don't have a lot of female Punjabi speaking members in the force"* (*Belle*) and, *"still have some trouble with recruiting" (Belle).*

> *The best department serves still short of 30 percent women. So there is an effort to recruit, to promote and engage more diverse or a more diverse population within policing. But it's still a long way to go rather than it's ever been and it's still not good enough. Probably there's no guarantee that whatever call happens, the South Asian police officer would be the one that goes to a call? (Penny)*

Participants believed the systems' structures play a big role in hindering access of services by ISAW experiencing IPV. One participant expressed the perception of power and its impact on women seeking help as the last resort:

> *Whether that's police or whether that's healthcare and you sort of have perceived perception of power, I mean anytime you're asking for help, you're in a vulnerable position and you're going to a place of power. And if you come from a place in which when people had power, it was utilized against you … It takes a huge amount of courage to take that or you must be in a completely and utterly intolerable desperate place in your life to then take that risk basically (Sherry).*

And the systemic barriers can be daunting:

> *Not necessarily as open and as accommodating, welcoming or inviting. Healthcare is something you need to identify a problem and then come to us (Sherry).*

The healthcare system is perceived as, *"a place where we have a tendency to silo people off" (Sherry),* and thus the presenting health concern is seen as, *"a disease and this is a symptom that's going on, but who you are as a person … is something quite separate. So we have an intervention that tries to separate it as well … so that can be complicated" (Sherry).*

She further elaborated on the silos in healthcare in the following manner:

> *In general, healthcare is not making that connection just yet. I mean there are some great people out there who do that work, but systemically across the board, we're still kind of siloed in that piece ...*

*So sometimes they think it's not going to be a helpful place for me to reach out to or they don't know that it could be a helpful place or that there's an option (Sherry).*

She elaborated that healthcare services are among the other essential services for women leaving abusive relationships, such as the police and the Ministry responsible for child protection. Hence, the current 'silos' service delivery, among these services, needed to be eradicated to achieve coordinated services for women. The role of MCFD is instrumental and cannot be minimised to ensure the health and safety of women. Coordinated and collaborative response to IPV is critical. She explained:

*Not only are there silos in addressing health concerns, there is a lack of cohesiveness in coordinating with other services. One such service is the Ministry of Child and Family Development (MCFD), which is responsible for child protection. As such BC is a province and in service provision MCFD is a really key player ... healthcare is important and yes, police are important, but I think for the vast majority of women in situations of domestic violence, MCFD is also a really significant player (Sherry).*

Another systemic problem is the lack of sustainable funding for IPV support services. The complexity of attaining sustainable and sufficient funding for programs and services for IPV survivors remains a challenge for responders and community social services. There is often project-based funding that is available annually, in contrast to the need for more stable ongoing funding. As participants pointed out:

*The one other thing is the funding, like so many of the community-based groups, they have to apply for funding. They don't have sustainable funding (Belle).*

While there was recognition of the existence of silos in systems and that this is where cross-coordination remains an outstanding need, having policies in place was a significant area. Several participants emphasised that focus was needed to ensure compliance to policies. The assurance that compliance to policies were present in every case, and especially in cases where there were additional challenges, was not to be taken for granted.

Participants agreed that while the increase in language-specific hiring of IPV responders is a positive step, there are several factors that should be taken into consideration to ensure that the health and safety of ISAW was not compromised. Hiring practices focused solely on increasing the language capacity of response services, without the appropriate IPV skills and cultural knowledge, negates its intended benefits:

*Systems have hired people as a token. They hire a one off Punjabi speaking worker but these professionals that they are hiring, they are born and brought up in North America and they have second hand knowledge about the experiences of being an immigrant or of their experiences. Again the language misinterpretation, cultural misinterpretation happens all the time (Preet).*

### 5.4.2. Fragmented and under-funded

Insufficient and unsustainable levels of funding to support IPV programs and services within healthcare is a concern that was raised. One example was:

*A big funding cut to the program [Woman Abuse Program at BC Women's Hospital] in the past. I know to this day, even though the program doesn't exist anymore, the social workers do meet with somebody and offer resources and support (Lin).*

Insufficient levels of government funding and limited initiatives covering the minimum services has resulted in more online resources or automated responses, which often raises safety concerns and culturally or linguistically appropriate or sensitive services. Online resources present an accessibility issue for ISAW as most resources are available only in English. Online resources also raise safety concerns due to the ability of abusers to track the history of sites visited by women seeking help online. Additionally, free clinics that provide medical services for individuals who cannot afford medical care have also been impacted by funding cuts:

> *Free clinics have been closing or the funding is on the cutting end. So where do you take these women? Pine Clinic closed down. So many of these women, they are suffering in silence … Not to paint a very negative picture, but that's the reality (Lin).*

The existence of free clinics was viewed as a resource, but the funding cuts faced by these clinics are further hurdles facing IPV survivors. To complicate the already limited resources in some communities, it is a challenge to gain access to doctors due to, " *not having enough doctors. I know that I repeatedly hear the recent newcomers say, Oh, I'm not able to find a doctor" (Preet).*

Making appropriate, timely referrals for services enhances support for ISAW when making decisions about leaving their abusive relationships. Understanding the referral process, being culturally sensitive and providing relevant resources was identified by participants as crucial for responders, as Preet explained:

> *These domestic violence teams .., it's not specific for the South Asian women … they make the referral to community grassroots organisation like ours, but a lot of times, I know there are volunteers on that call, that's how we lose many women during that process.*

Nevertheless, participants were encouraged that in some communities' healthcare practitioners, especially doctors, referred women experiencing IPV to community social services. One participant expressed that, "*having that referral I think is really good and I've heard that from clients as well"* and that the, *"relationship is built from there … having that referral process works" (Preet).*

On a cautionary note, referrals are more than just presenting ISAW with a few telephone numbers. ISAW also required a name and, additionally, contact information in order to take the first step in seeking help and establishing trust, and this is preferable, *"especially with South Asian women, they like to have a name" (Preet).*

Participants elaborated that ISAW were often intimidated and feared to get help from healthcare, police or community social services. Women referred by their doctor to community social services, found it beneficial to have a practitioner's name to contact. It was very helpful in facilitating the referral process and reinforced trust in health practitioners and their services. This is only feasible when healthcare practitioners are well-informed about community resources and comprehend the importance of appropriate and timely referrals.

> *So, having that name and then walking into a big building, into an office, with that name helps. I think that the personal connection definitely makes a huge difference for the women making the first contact (Preet).*

Despite various examples of how referrals and the referral processes are imperative for effective interventions, participants agreed that referral services are contingent on the service delivery structures currently in place. Participants confirmed that these referrals were not very effective and efficient based on evidence of more self-referrals to community social services in comparison to referrals made by system responders of IPV. It was in fact alarming that women were being deterred from seeking help from practitioners as a result of their lack of referrals to support services. Hence, "*anecdotally, when I look at my statistics, they are more self-referrals on my case, not a lot of them from the system. What does that say? Actually, the system is silencing people" (Leena).*

Participants highlighted the multiple barriers facing women when they seek emergency services in hospitals for IPV related injuries and health concerns. ISAW expressed feeling stigmatised in situations when they experience anxiety resulting from IPV. Their presenting psychological symptoms are diagnosed as mental health issues by emergency response staff without relating it to their IPV experiences but, in some instances, healthcare practitioners resort to calling the police and the child protection services. Both the police and the child protection services could have serious consequences for women when they are unaware and unprepared for them. Additionally, women are left waiting for long periods of time because of how busy emergency responders can be. One such situation was described as follows:

> *Whenever women have gone to ER or something's happened, it was either a nervous breakdown or anxiety, they're just so busy. That's what I have found, she sits and is waiting for that long (Lin).*

Preet highlighted that not only are the critical signs of IPV missed when women seek emergency medical attention, but in some cases, the hospitals resort to calling the transition houses. In this case, the woman is perceived as a persistent user of the hospital or ER services and resources because she feels unsafe to return home for the night. This is reflected in the high number of calls the transition house received:

> *In a week, six or seven calls from the social worker, from the ER, just because this person is using the bed of the hospital because they don't have a house (Preet).*

Unfortunately, Preet continued to express that:

> *But I don't get one call saying, this is what this person needs …. We saw her, she's suffering, there's some abuse going on …. She came here with anxiety or she had a nervous breakdown. We are not getting those referral pieces.*

The level of funding, coupled with increasing workloads of community social services, results in the decreased number of counselling and support hours per woman. An unfortunate consequence of this is, its direct impact on the quality of service to ISAW. Participants agreed that the limited time, increased accountability and completion of tasks directly impacted and compromised the practitioner's expression of empathy and engagement in service delivery to women.

> *There was a lack of empathy and lack of time. I think that the way we're kind of rushing, the traditional way of counselling or being humanistic is evaporating … There's so much focus on being accountable, doing the risk assessment and all that, but that, the whole notion about establishing that connection and especially more so with the newcomer, with immigrants. (Leena).*

### 5.4.3. Reactive policies and practices

There was recognition that extensive negative media coverage of IPV-related homicides of ISAW has been the impetus behind the development of policies and practices of systems in BC. These were often attempts by funders to respond to criticisms from the community and social service programs. This reactive, rather than proactive perspective, has perpetuated the persistent existence of systemic barriers affecting service delivery and responses. Participants expressed their frustration that there seems to be a reaction from systems only when women die as a result of IPV, but women seeking protection services are instead being minimised or silenced. Leena explained this historical context as follows:

> *I remember back in 2006, 2007 when so many South Asian women were murdered. The reaction or the way the police and the health and social services, everybody, the way the systems would react … now I'm finding that women calling and saying that to the police … being minimised ... women are being silenced again.*

She expressed her concern for the reactive nature of systems and questioned:

> *Why do we have to wait for a woman to be murdered, to be killed before the system reacts. All of these poor little South Asian Women ... we kind of patronise the women and then everybody jumps (Leena).*

There was recognition that government policies and directives were critical for service providers and for addressing IPV in communities. The need for clear messaging, along with the dedication of sufficient resources and funding for services, was clearly expressed by all participants. The "*meaningful messaging*" (Anne) is a key component of the government's role and a lack of sustainable funding is reflective of IPV tolerance in the province. The existing nature of government policies and resources was explained as:

> *What's disturbing about that is, there are two elements in terms of when you don't have policy or when you set policy that actually sort of withdraws services in a certain way. One, I mean concretely the services go away, but two, it sends a psychological message or it sends a voice out there that kind of diminishes the challenges that people face. Even kind of says this isn't a priority for us. Your issues are not a priority for us ... We're not concerned about that. Funding doesn't happen to target, the services. It kind of sends a message of tolerance and of a certain type of behaviour on the part of the government to an activity (Sherry).*

Participants also clearly indicated that messaging is critical and a, "*communication plan has to be developed. But that should come from government" (Belle)*.

Yet policies and protocols have to be created to function successfully within response systems to effectively increase the safety of ISAW:

> *So system created becomes useless because there's so many intricacies and in an extended family collective culture like South Asian culture, I think it's very, very possible for things not to work out the way one thinks a policy should work out or the protocol should work out (Simi).*

The efforts to address the needs of diverse women including ISAW in the near future was not compelling based on the following response echoed by participants and summarised as:

> *I'm not aware of any kind of new approaches or proposed approaches to serving immigrant women in a different fashion or that kind of thing ... we appreciate the fact that the policy that exists spells*

*out kind of the response, but there's clearly a difference between formal policy and then articulating … of best practice stuff and we've been working on that stuff for a long time around assessing risk for the purposes of safety planning (Terry).*

### 5.4.4. Rural inaccessibility

Women living in rural communities are further impacted by both accessibility and a shortage of services and resources. It aggravates the isolation and marginalisation affecting ISAW, as Pam articulates "*in these small towns … it's like the road is so long, so many challenges there".*

Rural geographic location results in isolation, increased distance from services, limited resources and the lack of ongoing funding restricting the availability and accessibility of ISAW's to IPV services for their health and safety. Participants emphasised the need to increase resources and services available to ISAW in these remote and rural communities across British Columbia. Pam communicated the situation as follows:

*When you get into these areas where there was a huge South Asian population, look at South Okanagan, so many families out there and to see that we're not even close to … a South Asian officer coming out, who can communicate, who understands something on a cultural level.*

## 5.5. Supportive Interventions

There was strong agreement among participants that the service providers need to acknowledge and understand that fragmentation of services is a present reality. A systemic commitment to training and funding is required to achieve coordinated and collaborative services. Sustained long-term funding and culturally and IPV-informed training are requisites for effective interventions to the creation of a positive change.

### 5.5.1. Coordinated and collaborative

Participants expressed optimism for work that can be undertaken to generate change by concentrating on improvements in policy and practice specific to ISAW experiencing IPV:

*I think there's always room for improvement. One of the challenges is, keep pushing into so many different areas to get better and better practice. It's very difficult to pull to a policy or protocol level to cover generically all British Columbians … you try and do some specialisation and you try and do some targeted work on specific client groups … probably more needs to happen (Terry).*

Similarly, another area for improved interventions was the increased availability and accessibility of resources due to the fact that:

*I don't think we do have a sufficient number of resources out there, interventions out there (Sherry).*

Interventions and improvements are necessary for the health and safety of ISAW and it requires a focus on addressing the low provincial rates of disclosures by ISAW despite the high rate of IPV:

*It's an evolving process. But I would say that in the South Asian community it's lower than what we would consider to be the provincial average of disclosure. But we also know that 22% of the files going before the courts are domestic violence files (Belle).*

Relative to healthcare, appropriate response by the practitioner is critical. Appropriate response entails being well-informed and trained culturally in IPV dynamics, which would result in timely and relevant referrals to community social services or other safety responders. It is just as essential for a practitioner to ensure that there is follow-up with the woman after a referral is made:

> *Because a lot of people do disclose in those settings, but the healthcare professionals don't know how to respond to that information in a way that's meaningful or they might give them a brochure or they might give them a pamphlet, but there's no follow up (Anne).*

Ultimately, it necessitated comprehensive intervention measures of collaboration across sectors and adherence to policies which need to be supported with:

> *More training, better policies, an understanding of collaboration, mentorship of our investigators, and mentorship of our victim service personnel so we can respond even better, tighter collaboration with transition house, better collaboration, with true collaboration with community service providers. We're doing great with good policies in place now. We just have to adhere to them (Belle).*

Regarding the improvement of preventive measures and practices, it is imperative that attention is paid to increasing the safety of women in order to decrease any escalation of risks to her and her children. Women should be able to get help prior to any incidence of serious health or safety breaches. It was crucial to concentrate on women who were categorised as low to medium risk instead of just concentrating only on the high risk cases and, in fact, the focus needs to be on the, *"low to medium risk in particular. Not just saying high risk, but low to medium risk" (Belle).*

One participant strongly suggested that the safety of ISAW be redefined and expanded to include the intersection of both the individual and the community. It should aim to, "*meet people where they're at so … looking at it from sort of a broader cultural safety and community safety perspective" (Anne).* And further clarifying that commitment to a wider range of services and resources:

> *There definitely needs to be a commitment on both the provincial and the federal level just in terms of funds. And also, I do think that there needs to be a way to rethink that, the safety. A new definition of safety about how you meet people where they're at, make sure they're safe as they define safety and give them options so that they can stay safe. So that there isn't the problem of returning to an abusive situation because I feel like there are no options for them in terms of affordable housing or supports for themselves or employment or school options for their kids (Anne).*

Participants mostly importantly emphasised responding from IPV trauma informed practice*:*

> *The general initiatives worth mentioning are trauma informed practice … we're working to strengthen the protection order regime around assisting women with serving protection orders (Penny).*

An elaborated intervention strategy to improving safety for ISAW should consist of the following key elements, according to Penny:

> *One of the most effective interventions, increasing the safety of South Asian women seeking healthcare or police intervention in BC is our appropriate strategic collaborative relationships that are solid, that we can actually know who to call, know who to get help with in the first instance, share information appropriately and expediently with someone that we've already met and*

> *developed a relationship with. That's critical. Critical because if you don't have that, you can't have an effective intervention.*

She continued to stress the importance of community engagement, in the establishment of a coordinated and collaborative service delivery approach. Simply enforcing interventions is not sufficient but, as she also stated, *"we need to make sure that our victim service personnel are highly engaged with the community-based services". And "another piece of this is that we have developed enough credibility with feminist-based, community-based agencies."*

In order to create cohesive responses, the development of trusting relationships within communities and among responders is pivotal. The achievement of a cohesive response among police responders is dependent on having:

> *To develop that relationship and that's really hard for Type A police officers to get to that point. It's because it's going by the book and they're so used to going there like black and white, like arrest or jail. And now we're asking more specialised people to build the relationship prior to, so that when you need to have an intervention, you can pick up the phone and make the call … you know, we're not experts … there's an inherent distrust of the police and trust is actually built by the individual police officers (Belle).*

Effective interventions entailed responding creatively and increasing the safety and well-being of women with, "*interventions that are out of the box - they can be so isolated and marginalised that you really have to think creatively about how to reach them and reach them where they're … give them safety and wellbeing" (Anne).*

The effective utilisation and understanding of resources can be a starting point to addressing IPV, instead of allowing it to persist and, hence:

> *Effective interventions would include things like having that list of resources available to you, even if they're not in a language that the person understands. There's a starting point where you can actually make that phone call and you know, someone can get help. The other piece of that is deciding how this training is going to look so that we can teach a little bit of that understanding of what collaboration is, and you kind of have to go about it in a different way with them because you have to say things like, this will actually save you time in the long run because you're going to be solving the problem instead of having it continue (Belle).*

At the community level, awareness of IPV within a community remains a significant factor and one participant deliberated the importance of:

> *Increasing awareness and understanding about violence … so that everybody's on the same page and they understand that what they're experiencing isn't necessarily normal … And then, who are able to communicate with them and respond to them were adequately trained and understand how to respond to their community (Penny).*

Public awareness campaigns, while imperative to increasing awareness in the community on the issue of IPV, inadvertently results in increased demand for under-resourced and insufficiently funded services, *"I think we need to embrace them, but then we have to be prepared to get those calls for service" (Belle).* The increased demand for services requires an increased capacity to support service delivery.

Fundamentally, effective interventions involves making a, *"practice shift"* (*Sherry*), and for healthcare, "*part of the practice shift is trying to also get healthcare providers to shift their practice away from what has been the more traditional, anything you tell me will remain confidential, to the more realistic" (Sherry).* Yet, it was confirmed that the shift in practice has not taken place, resulting in missed opportunities for IPV survivors:

> *Healthcare hasn't made that shift yet ... on the ground and natural sort of practical terms ... So there's a lot of … missed opportunities in healthcare, particularly because as women…and particularly if they're parents, they're often consistently connected to GPs and healthcare services (Sherry).*

These missed opportunities of identifying IPV within the fragmented healthcare care system need to be bridged to more holistic care through training:

> *Having the healthcare sector being focused on as a place where resources should be provided to train healthcare professionals, so that they can identify these issues and refer people in a meaningful way (Anne).*

Coordination and collaboration requires a provincially directed strategy to increase the awareness, understanding and effective response for improving the health and safety of ISAW. This strategy will have to be accomplished through the establishment of trust and seamless support among systems. Accordingly, "*officers have success when they've built the trust relationship at the hospital level and expanding it to build that trust province-wide instead of them individually doing it*" (Belle).

Participants were realistic in their expectations and reported:

> *The word collaboration is of course, work. It's really hard work. And the trust building … the trust is built with credibility, trust is what it comes down to (Belle).*

There was acknowledgement that, as a consequence of the work that has been done, continued rendering success among service responders:

> *We're much stronger in that field around managing risk and working more closely with our partners to develop safety plans and stuff like that … it's more coordinated and cohesive (Penny).*

In summary, potential interventions by the government needed to be clear and consistent in its messaging and non-tolerance of IPV, especially among new immigrants to Canada:

> *Government could be more explicit about some messaging that domestic violence is not tolerated. And if you are someone who is in that situation and you are an immigrant to this country, you will be supported to be in a safe place regardless. And it will not impact your immigration status or your plans or your relationship with your children and your custody of the children. But that's never really explicitly stated. It's an exception somewhere, but not practice (Sherry).*

### 5.5.2. Essential services for new immigrants

Participants responded with clear recommendations for the government to address the increased rate of IPV among new immigrants to Canada. Clear information about the laws and policies around IPV are essential upon the arrival of immigrants, in addition to healthcare and police protection services and resources. Priya outlined it as "*zero tolerance, so telling them, before they start living or even before they start coming here".*

Another participant added that:

> *We're the ones who are calling the immigrants and then we expect the immigrants to deal with their issues on their own (Priya).*

While the healthcare system itself has limitations, the immigration status of new immigrants limits their access to medical services for the first three months of their arrival. Government policies affect ISAW, who could be experiencing IPV within the first three months of their arrival in Canada, as a result of their immigration status. Leena explained the complications and complexities that women face due to the lack of services and knowledge as new immigrants resulting from their limited access to medical services:

> *Not having coverage for the first three months, medical services plan or coverage. I get so many young women, young girls who just recently arrived in Canada and they have been going through horrendous abuse … it's very complex if you think about it. There are so many gaps and … when you're talking about immigrants, South Asian women.*

Although the conditional Permanent Resident parameters were removed for new immigrants in 2017, the lack of medical services coverage for the first three months of their arrival in Canada continued.

Culturally sensitive, IPV-informed practitioners with linguistically appropriate training skills, equipped with sufficient resources and funding, would be promising steps towards meeting the needs of ISAW across the province. The improved policies and practices that were suggested included:

> *The training. I think that there needs to be a good training piece (Preet).*

Cultural understanding of the patriarchal family structures of ISAW and its importance in training for health and police responders was highlighted by most of the participants:

> *Gender sensitisation training for police officers and for medical faculty and understanding the dynamics of gender in the South Asian community (Priya).*
>
> *It's always more important to teach men and to send them for some kind of orientation and training for men to think out of the box (Pam).*
>
> *For people who are hired just because they speak Punjabi language … they also need a good training (Leena).*

### 5.5.3. Trust at first contact

Participants unanimously agreed that the first contact with ISAW was critical as it provided an opportunity for the responder to establish trust with the IPV survivor:

> *To establish that first initial contact with any woman with empathy and to have respect for her time and to spend time. I think because of lack of time that we as service providers … we are doing injustice (Leena).*

Accordingly:

> *It doesn't matter, it's healthcare, it's police, or it's social services … not the quantity, it's the quality work. Because the knowledge of where the services are, where it is safe to go, to integrate more of those things together so they're (women) not silenced (Preet).*

A community healthcare initiative was mentioned as one positive initiative for ISAW. It involved well-informed and trained community health nurses in Vancouver and, "*… they are playing a very important and vital role and, over the years, we see that there is an increase in the community health nurses" (Leena).* The community health nurses are resourceful and knowledgeable in making referrals to community resources for ISAW in the Metro Vancouver area because they are, "*very sensitive to specific needs of the South Asian community and especially for the women" (Leena)* and, being aware of, "*issues that the women are experiencing and having the skills and the knowledge and of what are the appropriate questions to ask when the women come in, makes a huge difference" (Leena).* A similar initiative would be an asset for other healthcare practitioners.

It was clear and, there was agreement, that training is critical for the knowledge and skill enhancement of practitioners. Some of these skills include their comfort with asking questions about IPV, recognising signs and being cognisant of cultural and linguistic appropriateness. It was acknowledged and articulated that practitioners ought to practice due diligence in providing information while respecting the choice and readiness of ISAW to disclose or report IPV. Referrals by healthcare practitioners to appropriate community services such as victim assistance and transition houses are vital as:

> *It's a different story if the women will remove herself from the abusive, violent situation, but at least there is some intervention. At least the public health nurses are able to connect the women to organisations that are providing these services … And eventually over the years I've seen that the women, when they are ready, they will reconnect with the organisations (Leena).*

Similarly, police response has improved in some areas of the province. Participants indicated that referrals to healthcare and community social services should be timely and consistent. Police refer to community-based victim assistance programs, and these programs provide critical practical and emotional support for ISAW. Referrals increase the health and safety of the woman, while improving the coordination and collaboration between services:

> *Once this sort of thing gets reported to the police, if the police would suggest that it is better for her to get in touch with the [community] victim support services worker (Leena).*

Participants unanimously agreed that improvements in service delivery require strong endorsement and political will to create the necessary and culturally and linguistically appropriate policies and practices for ISAW. Preet clarified that while, "*there are some good policies and procedures for both health and the police systems",* for any policy and practice to successfully meet the needs of ISAW, it needs to be "*differentiated for immigrants from South Asia … you can't put everyone … under a general, big blanket".*

### 5.5.4. Cross-sectoral training

An intervention advocated by participants was education and training of both healthcare and police responders. Efforts to enhanced training and education for healthcare in IPV has been successful, although these have not been specific to ISAW. Lin explained:

> *Trauma informed IPV education and training has improved response, resulting in services being more informed, sensitive and consistent. Although this training was not specifically focused on the*

*culturally diverse needs of ISAW, it was observed that in the hospital setting, in general, over the years that there are people who are more sensitive … So I think there has been some headway in the healthcare fields around training, so understanding violence against women better, certainly better support than it used to be but a long way to go" (Lin).*

As preventive strategies for ISAW experiencing IPV, participants recommended training and education across multiple services – community awareness, in school systems, medical and nursing schools, justice systems and as part of professional development for all service providers. As such, mandatory education of healthy relationships is essential in the school system, as:

*Prevention is better than cure. So, there should be something mandatory and in place where everybody has to know. (Preet).*

The training of police officers and healthcare practitioners requires an in-depth understanding of IPV and the cultural and linguistic dynamics, with opportunities for a comprehensive application of these skills in practice. As Leena explained, there is only limited training in place for police officers:

*I know right now the RCMP … they only get four hours of training, of the domestic violence.*

In comparison, volunteers in transition houses and community social services who provide crisis and practical support to IPV survivors go through more intensive and rigorous training programs:

*My volunteers receive over 60 hours of training just to do volunteer work … if a good training is given by people like us, every police officer should hear my story about this client … that would start shifting … It's just not that a doctor has to spend three hours of counselling (Preet).*

The need for trauma informed IPV training for medical and nursing students was an ongoing concern expressed by participants. Lin explains the situation for medical students in particular:

*Going to UBC VGH (University of British Columbia, Vancouver General Hospital) medical students' tutorials … I was disappointed with basically how they were spending three to four hours talking about intimate partner violence and they are becoming doctors. There was so much of disinterest by these students. They were fatigued, they were exhausted. They didn't want to talk about it and here I'm … engaging and hoping they would ask questions and I would respond ... There was silence (Lin).*

Participants perceived a disconnection between the importance of the role of first responders and their skills and training: "*for the perspective of the folks that are first on scene, the training, like I don't even think they realise that how important [it is] or that they need to be trained on it" (Leena).*

### 5.5.5. Assessment

Appropriate interventions improve response to IPV, and it is important that timely and effective service delivery to ISAW is in place. Although assessment tools are available in healthcare, participants acknowledged the lack of IPV trauma informed and culturally appropriate assessment tools for ISAW, and proposed the importance of having them in place. In fact, there was concern for the existing assessment tools, as in:

*Health care … there aren't assessment tools in place even to ask appropriate questions for women to open up (Leena).*

Leena provided an example about the lack of tools:

*The healthcare does not want to dwell deeper into the psychosomatic symptoms that the woman is displaying. She has come and she has talked about the stomach pain. Is there another connection to it?... that is where it doesn't happen because of the time, again, coming back to eight minutes, unless it's a very reasonable, like when a woman ends up in the hospital and these are visible signs … somebody else can take care of this thing … not their client and not giving another referral.*

The use of generic checklists in healthcare, police and community social services – developed to meet the needs of western white women – is problematic. These checklists do not equip responders in healthcare and, the police, with tools that are culturally appropriate and sensitive, and do not have the capacity to adequately assist practitioners across the various systems. Preet explains:

*There's a checklist for a social worker who works for the ministry. So even when a police officer goes into a home ... when you're working with the South Asian family, I think those checklists are not really helpful … these checklists are done in a very western way ... you know, it doesn't work.*

Similarly, within the healthcare system, there is a lack of consistency and tracking of compliance as it was agreed that while:

*We do have policies. We are expected to ask every woman as they access healthcare services, if they have an experience around intimate partner or domestic violence at one point in time. I think for many of the health authorities that the policy was followed fairly consistently, but like any sort of policy if you are within healthcare, if you don't have somebody monitoring compliance and doing chart audits and things like that, it sort of falls by the wayside (Sherry).*

Trained responders would facilitate appropriate and timely help-seeking by ISAW. Healthcare practitioners are pivotal for the health and safety of ISAW and there was compelling evidence of the possible results:

*Have training for paediatricians, for ER docs, for treating physicians, for nurse practitioners or if there's visiting nurses or if you've got a drop-in clinic. Make sure that they are aware of some of the signs and symptoms related to domestic and sexual violence … for there to be disclosure, that safety net is strengthened.*

And *... in terms of police intervention, if someone discloses a crime to the police, you want to have an interpreter. You want to have ... adequate and effective victim services provided to them (Anne).*

Healthcare practitioners need to be trained to recognise IPV and have the skill to ask about IPV. Asking appropriate questions and offering referrals to services are effective interventions for ISAW accordingly, to avoid current situations, as Sherry elaborated:

*So there is some tension between asking the question and sort of putting somebody on the spot … but if you don't ask … very rarely will we actually volunteer the information. So, I feel as practitioners, become more comfortable with having the conversation … it will also normalise. Our expectation is you ask.*

The provision of knowledge and skill with opportunities for deepening understanding starts with training and skill development and this was articulated by participants:

> *Training and exposure to different cultures. A lot of that is training, training, training (Penny).*

And the vulnerabilities faced by ISAW require IPV understanding and sensitivity:

> *All officers having an understanding that when that woman comes to the counter, particularly if she comes from a culture, they need to be sensitive to that (Belle).*

And yet another participant commented:

> *Training is critical so that they don't brush everyone with the same brush, that they see the differences and that they recognise the vulnerabilities … If people who are the healthcare professionals are trained as a way to identify the issues and then know where to refer the person and it's a good referral that's going to help the person that could really redefine a kind of safety net and make it a real safety net, not just one that we're constantly trying to patch (Anne).*

Further discussion clarified that simply encouraging ISAW to disclose would not be sufficient. In fact, it had the potential to increase their health and safety risks if healthcare professionals did not respond appropriately, as one interviewee explained:

> *Just increasing the disclosure rates, without having the resources and responses to match them, will only be reflective of current situations … because a lot of people do disclose in those settings, but the healthcare professionals don't know how to respond to that information in a way that's meaningful or they might give them a brochure or they might give them a pamphlet, but there's no follow up (Anne).*

Based on the police statistics, the ongoing homicide rates are indicative of a general decrease in the number of women seeking police protection when experiencing IPV:

> *We have made progress in the last 30 years, I don't think there's a doubt about that ...Things like spousal homicides are down over 30 years. BC has recorded a significant decline in self-reported spousal violence rates from a 7.5% in 2004 down to 4.2% in 2014 …The rate of homicides within the South Asian community have remained consistently high, like they've been since 1996 and accordingly, …90 percent of immigrant women do not report to police. So that's pretty significant (Terry).*

Interventions require significant coordination and collaboration between systems, and participants emphasised it. Policy changes and funding initiatives will have to be in place for such interventions to materialise, as it was expressed:

> *A lot more needs to be done …It's only through research, through public opinion … when organisations become proactive and policy has changed. It's a long road and taking input from the community itself (Leena).*

Regarding the role of the government and policymakers, it is important to understand the impact of decision-makers and how informed they are, as:

> *What I would just like to add to that is, whose voices are being heard by the government and who is making the policies, who are the policy makers…? (Priya).*

Participants agreed that, "*we've come a long way, but we definitely have a long way to go to … support many different communities and that includes the South Asian*" (Penny), in addressing IPV on a provincial level. There was disappointment when participants reflected on the measurement of the effort to date against the homicide rates in BC:

> *We're not seeing a total drop in (homicides) there despite everything's been done. I think that's, that's been enough concern for me for despite all this all the other communities need to have. Resources … and collaboration support (Terry).*

## 5.6. Chapter Summary

The results of Phase One of the qualitative data, which includes the service providers' focus group and the key informant interviews with the policy makers, policy analysts and management professionals, have been reported in this chapter. The four main themes in this chapter were: Service responses; Gaps in service delivery; Systemic barriers and Supportive interventions. The service response challenges included socio-cultural values and norms, perceptions of responders, response time and balancing cultural and IPV knowledge and skills. The systemic barriers included the fragmented and under-funded services, and the reactive policies and practices. The supportive interventions included coordinated and collaborative services and systems and cross-sectoral, culturally and linguistically informed, training and enhanced capacity. A deeper understanding of socio-cultural constructs and IPV dynamics, monitoring the development, implementation and consistent application of policies and practices, systems response and structure, with supportive and clear messaging and effective interventions at all levels, remains essential for the health and safety of ISAW.

The findings presented in this chapter provide critical understanding of the complexity and multi-layered intricacies influencing the service delivery and help-seeking strategies for improving the health and safety of ISAW. A discussion of findings presented in this chapter will be provided in Chapter 7, which integrates the findings of Phases One and Two. Highlights of the key issues are presented relative to service delivery of IPV services to ISAW.

# Chapter 6. Quantitative Results: Frontline Service Providers

## 6.1. Introduction

Chapter 3 outlined the study design and methods, its application, the sample selection and data collection procedures. The aim of the study was to examine and understand the needs of ISAW in BC, Canada, who experienced IPV and interacted with healthcare and police services. The qualitative results of the study are presented in Chapters 4 and 5, while the quantitative data results are presented in this chapter. This chapter incorporates the overall response rate and the data gathered from the online survey of frontline responders and provides a descriptive analysis of the quantitative findings (Phase Two). In the next chapter, an integrative discussion of the findings is presented on both the qualitative and quantitative data.

A purposive sampling strategy was employed for Phase Two, consisting of a representation of the three groups of frontline responders: healthcare providers, police, and community social services of the province of British Columbia. In keeping with the aim of the study, the perceptions of the needs of ISAW experiencing IPV, accessing healthcare and police services was sought from all three groups to assist in answering the research questions to improve the health and safety of ISAW. The online survey consisted of three primary sections. The first section of the survey collected brief demographic data of the participants (Appendix C). In accordance with the confidentiality assured to participants, the demographic data sought was kept to a minimum, in order to preserve the anonymity of the participants. The second section of the survey related to the service needs and gaps encountered by ISAW accessing healthcare and police services, while the third section focused on the recommendations and interventions of participants to improve the health and the safety of ISAW. The participation of community social services in the online survey was sought, as this is an important component of support and advocacy for ISAW accessing both healthcare and police services, contributing to an insight of the multiple vulnerabilities and recommendations to improve healthcare and service delivery. ISAW women may seek community social services, particularly multicultural and community-based victim services, settlement and transition housing services prior to disclosing to healthcare practitioners, seeking police protection or other justice-related services. Therefore, the participation of community social services was perceived as an important element of Phase two data collection.

The overall response rate of Phase Two of the study was n= 128/304 (42.1%), achieving an error level of 6.6% and a 95% confidence interval (https://www.custominsight.com/articles/random-sample-calculator.asp). The survey was administered in December and extended till the end of January, reflecting a response rate attributable to the holiday season and also the general increase in workload for workers, including the lower response rate for healthcare practitioners (Gutmanis et al., 2007). The help-seeking and disclosure of IPV to healthcare and police responders was compared to understand future interventions based on current situations of ISAW. Participants were asked for extended responses to some questions. They are reported as narrative and within tables and graphs. Data also provided descriptive analysis of perceptions of barriers faced by ISAW when accessing healthcare and police services. In addition, the

descriptive analysis provided in-depth understanding and comparison of the interventions and policies that can increase the safety and health of ISAW. Any similarities and differences between the responses of healthcare and police was derived from the analysis.

The response rate of the online survey is reported first, followed by the brief profiles of the participants. Descriptive techniques are used to report the data, utilising graphs and tables where appropriate. Each question was analysed, and related items were then summed up for each section to understand the needs and gaps facing ISAW and the recommended interventions to improve their health and safety. Comparisons are made for each section under related themes, followed by a data report of the analysis for healthcare and police responses. A description of the narrative responses follows and the key findings are summarised for the discussion chapter that follows.

## 6.2. Survey Results

### 6.2.1. Survey response rates – frontline service providers

A total of 304 online survey emails were distributed to contact persons in organisations and provincial associations from all three participant groups: community social services, healthcare and police services. The number of responders varied across groups. Due to the anonymous nature of the responses, it was not possible to determine how many participants had more than one role or if they responded to the survey more than once in a dual role. The overall response rate of Phase Two of the study was 42% (n=128/304).

The 30-item survey consisted of predominantly structured questions. A variety of survey questions were utilised in the online survey (Trochim & Land, 1982). Dichotomous questions were used to gather data relating to the perception of participants. Unstructured questions included comments by participants relating to the gaps in services and promising practices in healthcare and police service delivery approaches. Several questions allowed multiple options that permitted participants to tick the applicable check boxes covered in a checklist, in addition to contingency questions, providing an insight into situational possibilities. In order to maintain the anonymity of the participants, their gender, years of employment, employment status and community of work were not included in the questions.

## 6.3. Survey participant profiles

### 6.3.1. Roles

The response rate from each group of participants is displayed in Table 6.1 according to their workplace affiliation. It provides a broad representation of the participants and their perspectives for the study and corroboration of the results provided by the focus groups and the interviews of Phase One.

**Table 6.1: Workplace of online survey frontline responders**

| Participants roles | Frequency (N) | Percent |
|---|---|---|
| Community-based victim services | 29 | 17.9% |
| Police-based victim services | 29 | 17.9% |
| Transition/Safe House | 30 | 18.5% |
| Stopping The Violence counselling | 23 | 14.2% |
| Stopping The Violence Outreach | 11 | 6.8% |
| Multicultural Outreach | 6 | 3.7% |
| Settlement | 1 | 0.6% |
| ELSA (English Language Services for Adults programs) | 1 | 0.6% |
| Nurse/Health care Practitioner | 1 | 0.62% |
| Police/RCMP | 4 | 2.5% |
| Other | 27 | 16.7% |
| Total | 162 | 100.0% |

A total of ten categories of professional roles were provided for participants to tick the most applicable to their work. The following work roles were specified under the 'other' category and these were:

- PEACE program workers, providing psychoeducational support to children impacted by IPV
- Sexual assault nurse examiners
- Correctional staff
- Government workers from the Ministry of Child and Family Development
- Funders
- Provincial government
- Representatives from research and policy into violence against women and girls.

In calculating the workplace frequencies, PEACE workers were included in the Transition/Safe Houses category and, the sexual assault nurse examiner and a participant from the BC Women's Sexual Assault Service, were combined in the category of nurse/health care practitioner.

Table 6.2 depicts the service providers who did not identify with the major categories provided as options in the survey. This diversity of participants expanded the data collected and enhanced the results of the online survey.

**Table 6.2: Additional workplaces of survey participants**

| Survey participants | Frequency |
|---|---|
| Administrative staff for community services | 1 |
| Community Living | 1 |
| Correctional Centre | 1 |
| Director of all services | 1 |
| Family Counselling | 1 |
| Family Law Advocate | 1 |
| Government Funder | 1 |
| Homeless Prevention (Transition House) | 1 |
| Ministry of Children and Family Development (child protection) | 3 |
| Native Court worker - Family & Youth Advocate | 1 |
| Provincial Government (Ministry responsible for child protection) | 1 |
| Research and policy of violence against women and girls | 1 |

### 6.3.2. Participant professional role

A large number of the participants were employed in the community social services (n=113), referred to as community-based victim services, transition/safe house, stopping the violence counselling and outreach, multicultural outreach, settlement, and administrative, whereas 33 were police and police victim services. There was a low representation of participants from healthcare (n=3). Similarly, three participants represented the government, including a funder of services and two from the Ministry of Children and Family Development, whereas one identified with the research and policy of violence against women and girls.

## 6.4. Survey item results

The 30 items of the online survey for service providers was designed to provide an insight of the IPV of ISAW across BC and, ways to enhance their health and safety, was divided into two sections:

Part 1: Domestic Violence: Immigrant South Asian Women - Service Needs and Gaps

Part 2: Increasing Accessibility/Resources – overall accessibility

i. Accessing Healthcare

ii. Accessing Police Protection

A complete list of the survey items in the two sections can be found in Appendix D.

## 6.5. Service delivery to ISAW across BC

The questions in this section provided information regarding who ISAW disclosed IPV to, the age of the women seeking services and the language preference when seeking services. This is followed by the confirmation of service delivery, the awareness regarding the existence of IPV of ISAW in communities and the levels of service delivery over a three year period between 2012 and 2015.

### 6.5.1. Disclosure of IPV by ISAW

ISAW disclosed directly to service providers such as, multicultural and community-based victim service workers and transition house workers in 21% (n=61) of the cases. These direct disclosures included disclosures to settlement workers when seeking services not related to IPV, but encompassing language and skill enhancement training and assistance. There were also a smaller number of indirect disclosures (12%) made by ISAW when seeking other non-IPV related services, including the school and educational institutions. Figure 6.1 below depicts information regarding all the entry points for disclosures by ISAW who accessed services. The survey revealed that 17% (n=48) of the women experiencing IPV disclosed the abuse to support people in their lives, including family and friends. In other cases, ISAW disclosed to service providers when they were seeking referrals for other services not related to their abuse.

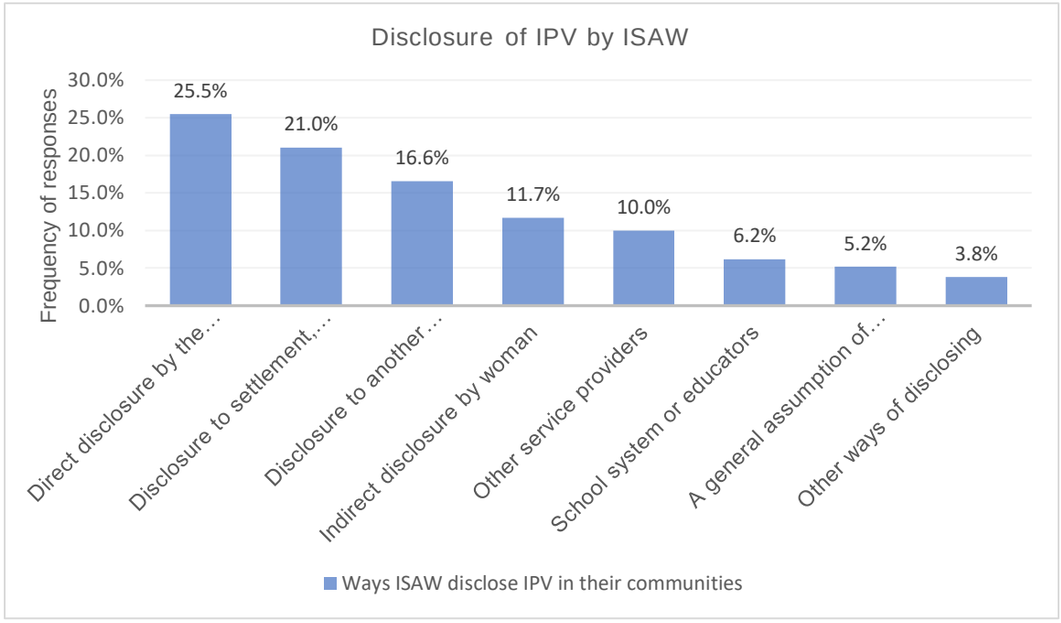



**Figure 6.1: Entry points for disclosures/help-seeking by ISAW for IPV**

Additional comments by frontline workers elaborated the other means and circumstances of disclosures by ISAW in their communities and these comprised:

- disclosure by their children
- in support groups for women

### 6.5.2. Age of ISAW seeking services

The highest number of ISAW seeking services were between the ages of 26-35 years, as shown in Figure 6.2. The service providers indicated that the average age of women for 65% of the women accessing services ranged between 21 to 45 years of age. Services were also available to children and youth who witnessed the IPV in their homes, and this was indicated by service providers for 16 to 20 year olds. In this question, participants were able to check multiple age groups.

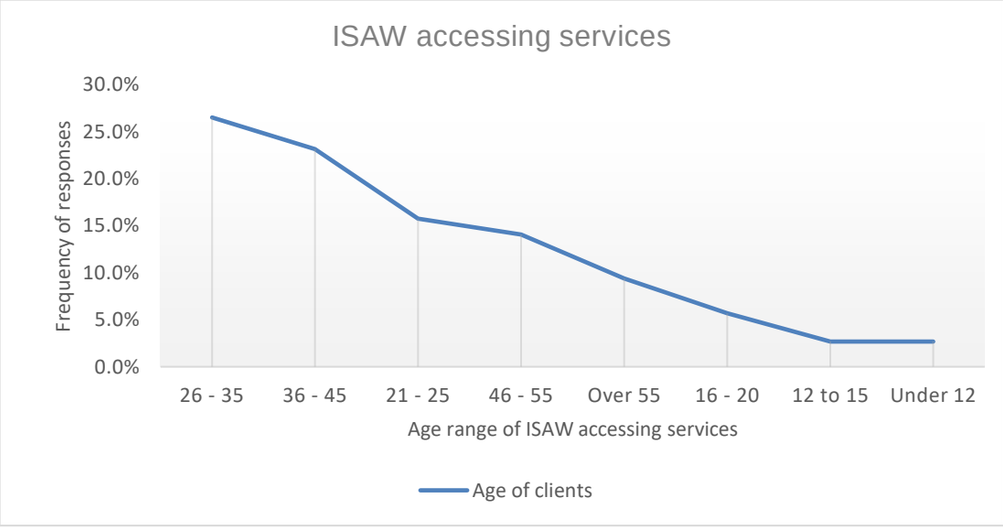



**Figure 6.2: Age of ISAW accessing IPV support services**

### 6.5.3. Language specific services for ISAW

Participants confirmed that 35% (n=45) of the ISAW spoke primarily in Punjabi when accessing the services. Approximately 49% (n=63) of the service providers did not know the primary language of the women, which indicated that they were able to communicate in English with the women who accessed their services, or did not have direct communication with the women. Participants were only permitted to select a single language in the survey to indicate the primary language preference of the ISAW (Figure 6.3).

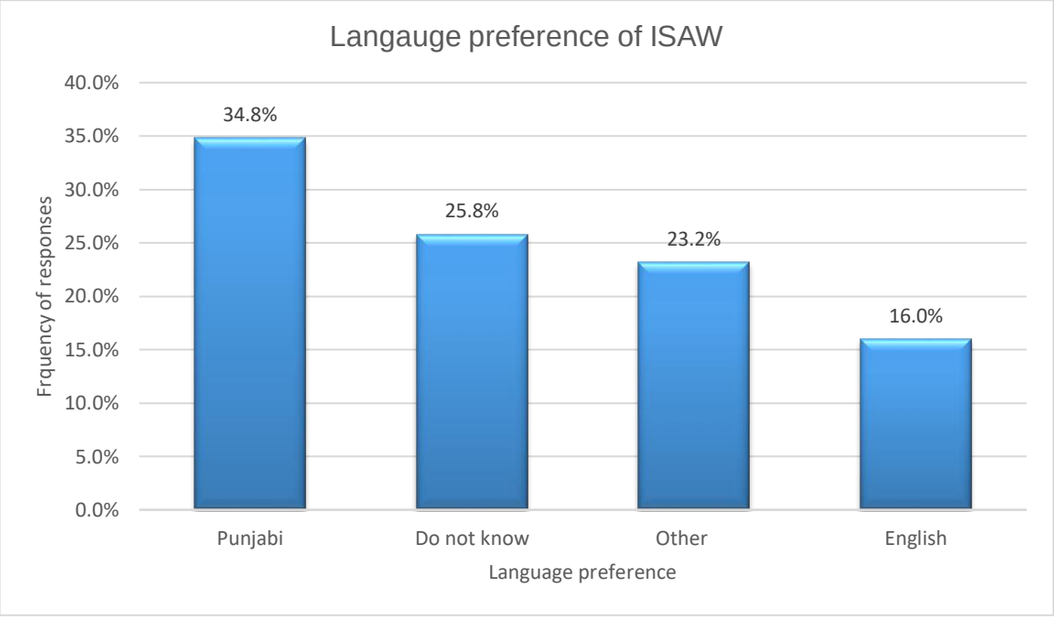



**Figure 6.3: Language preference of ISAW accessing services**

### 6.5.4. Service delivery levels

Participants were asked to confirm the delivery of direct practical services to ISAW across BC (Table 6.3). Although respondents did not answer all questions, a large number of the frontline workers; 79%, confirmed that they had provided services to ISAW.

**Table 6.3: Practical assistance delivered to ISAW**

| Practical assistance | Frequency (N=124/128) | % |
|---|---|---|
| Yes | 98 | 79.0% |
| No | 18 | 14.5% |
| Do not know | 8 | 6.5% |
| Total | 124 | 100% |

### 6.6.5. Existence of IPV of ISAW in communities across BC

The question, “are you aware of IPV experienced by ISAW in your community?”, referred to situations across the province of known or suspected incidences of IPV in rural and urban communities (Table 6.4). This question was not answered by all respondents, yet a high number of participants (79%) were aware or suspected that such incidences prevailed in their communities, while the remaining 21% indicated the non-existence, or not being aware of IPV incidences, of ISAW. The non-existence of IPV of ISAW, or the lack of knowledge of such incidences, pointed to the possibility of communities that were non-inhabited by ISAW and/or the non-disclosure or such incidences.

**Table 6.4: Knowledge of IPV among ISAW in communities**

| Knowledge of IPV | Frequency (N=125/128 | % |
|---|---|---|
| Yes | 99 | 79.2% |
| No | 11 | 8.8% |
| Do not know | 15 | 12.0% |
| Total | 125 | 100% |

A comparison of the number of workers who had assisted ISAW and the number of workers who suspected or had known of the incidences of IPV among ISAW in their communities was almost identical at approximately 80%, indicating that the participants were aware of the existence of these IPV situations in their communities, even if they had not practically assisted them (Table 6.3 and 6.4).

### 6.5.6. Service delivery over a three year period (2012-2015)

Over a three year period (2012-2015), 40% (n=50) of the frontline workers only provided services to less than five ISAW in comparison to 16% (n=20) of the workers who serviced more than 20 ISAW. Yet, within that same three year period, approximately 18% (n=23) assisted between 6 and 20 ISAW in their communities. Importantly, 11% (n=14) of the frontline workers revealed that they did not provide any services to ISAW within this period (Figure 6.4). It is important to note that almost half of the participants either did not provide any service or assisted less than five ISAW in three years.

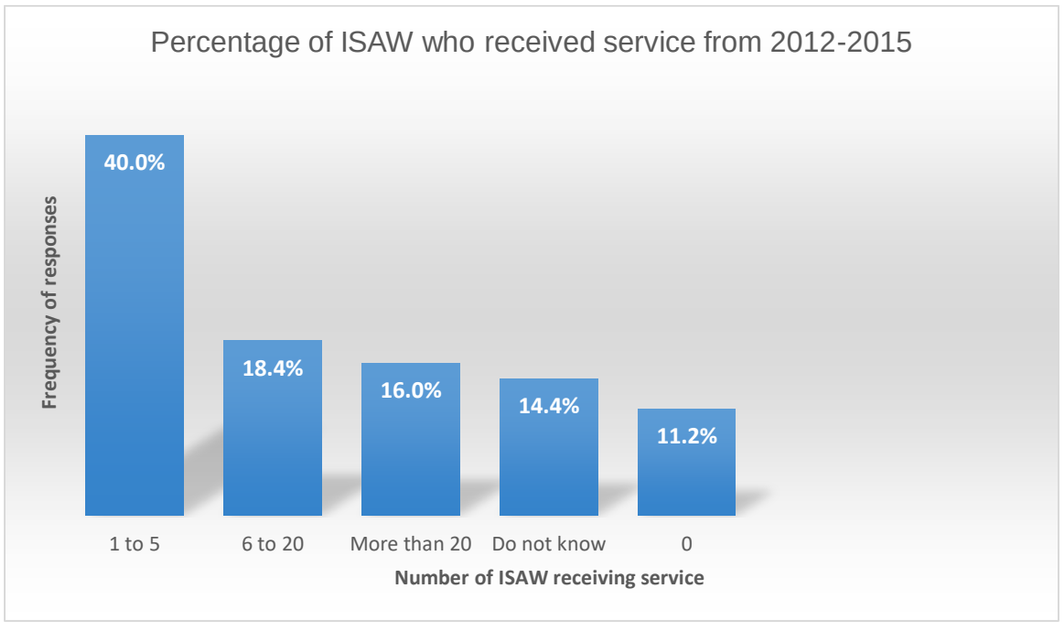



**Figure 6.4: Percentage of ISAW accessing services between the years 2012 – 2015**

## 6.6. Challenges to accessing services

Participants substantiated the challenges ISAW encountered with multiple factors when they attempted to access healthcare or police services across the province. The three fundamental reasons that prohibited ISAW from seeking services were the fear of the unknown, associated with their future and that of their children (10%), the apprehension about the socio-cultural repercussions for them and their extended family members (9%) and the lack of knowledge related to both the medical and police systems (9%). The deprivation of support from the family and community, isolation, and the lack of privacy when accessing medical services further implicated and hindered their access to services. Table 6.5 below provides a list of these challenges. Participants were provided with the lists that permitted them to check more than one issue in their answers.

**Table 6.5: Challenges to accessing healthcare and police services by ISAW**

| Challenges to accessing healthcare or police services by ISAW | N | % |
|---|---|---|
| Fear of what could happen to them or their children if they report to the police | 119 | 9.5% |
| Worry about social and cultural implications for them, their children, parents and relatives | 118 | 9.5% |
| Lack of knowledge regarding the medical and police systems | 114 | 9.1% |
| Isolated from family and friends | 111 | 8.9% |
| New to the community/country | 110 | 8.8% |
| Being a good daughter/wife and keeping the domestic violence a private matter | 109 | 8.7% |
| Fear of being deported or losing their immigration status | 109 | 8.7% |
| Maintaining family peace | 104 | 8.3% |
| Lack of support from the community and/or family if they choose to report to the police or disclose to health care practitioners | 94 | 7.5% |
| Patriarchal structure | 82 | 6.6% |
| Not allowed to visit the doctor without a family member | 67 | 5.4% |
| Do not have access to a phone/Internet | 58 | 4.7% |
| Produce a son/extend the lineage | 34 | 2.7% |
| Other, please specify | 19 | 1.5% |
| Total | 1248 | 100% |

Frontline workers provided a more comprehensive list of open-ended comments of the challenges facing ISAW in their communities and commented that these were clearly the language barriers and availability of translation services, the economic and financial dependence on their spouses, among others. These are listed below in Table 6.6.

**Table 6.6: Additional challenges facing ISAW**

| |
|---|
| “Stigma” |
| “Have had sponsorship cancelled” |
| “Not being believed by the authorities when they report” |
| “Social status and financial reasons” |
| “In some format all of the above are barriers to each and every South Asian immigrant woman if she is in a power-based violence situation” |
| “Still loving him and wanting him to change” |
| “Fear for their family members outside of Canada, no access or info about finances, not enough English language, etc.” |
| “Husband in position of power; employer, no respect for women's rights or dignity; women’s immediate family & friends” |
| “Systems that aren't aware of/don't practice cultural safety and thus women have negative (re-traumatising, shaming, discriminatory and/or racist practitioners/policies; language barriers) experiences when they reach out for support” |
| “Threats of bodily harm” |
| “Judgement from wider community that this is what "South Asian society is like" |

The survey participants represented both rural and urban communities across the province. Participants answered a series of questions relating to their perceptions of barriers, their provision of services, awareness of IPV in their communities, the existence of specific guidelines for service to ISAW and knowledge of improvements to accessibility. Figure 6.5 is constructed to reflect the cumulative responses of participants to a series of questions. The participants responded to a series of questions relating to:

1. barriers faced by ISAW when accessing healthcare and police services,
2. assistance provided to ISAW,
3. their awareness of the existence of IPV of ISAW in their communities,
4. the existence of specific guidelines for working with ISAW within their organisations and
5. discussions within their organisations to improve accessibility to services by ISAW.

A comparison of the above determinants exhibits the existence of barriers that ISAW encountered when accessing healthcare and police services whilst affirming that despite such barriers, community social service organisations, healthcare and police, persists in improving accessibility to ISAW in their communities. A notable number of participants (79%) were aware of IPV of ISAW in their communities. However, it is also important to note that a sizeable proportion of the organisations (61%) did not have specific guidelines in place to support the challenges faced by ISAW. Despite the lack of specific guidelines, almost half of frontline workers (48%) endorsed that the improvements to service delivery and accessibility of services for ISAW were discussed within their various organisations.

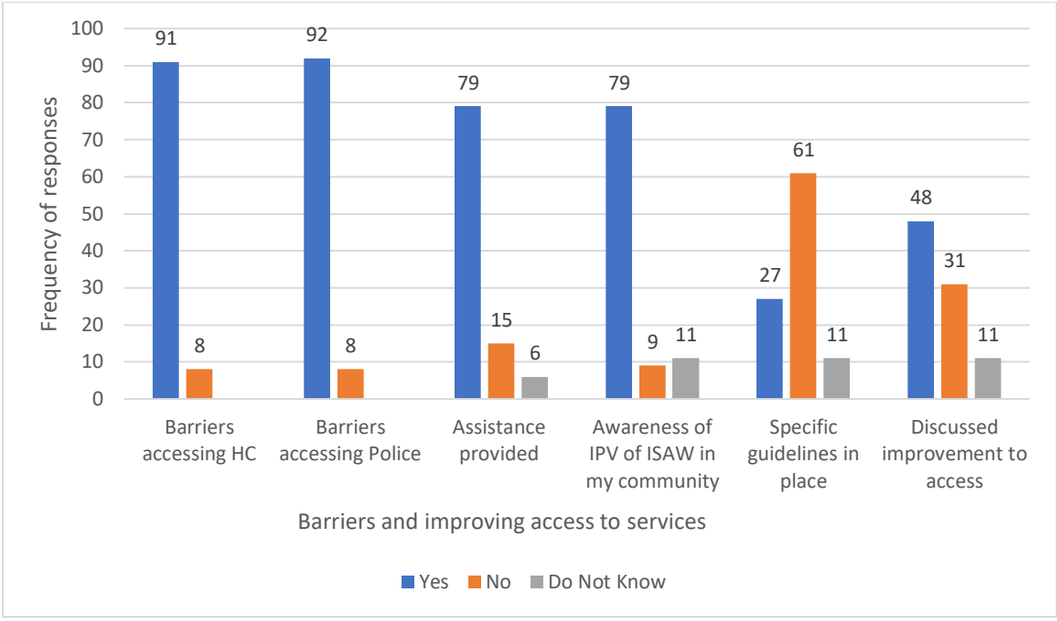



**Figure 6.5: Determinants of IPV related services for ISAW in BC**

### 6.6.1. The perception of healthcare and police services

A closer examination of the participant responses relating to their perceptions of barriers to accessing healthcare and police services revealed that a vast majority of the participants (92%), believed that ISAW experiencing IPV faced barriers when accessing healthcare services in the province. Similarly, 89% of the participants indicated that ISAW faced barriers when accessing police protection, evident in Tables 6.7 and 6.8.

**Table 6.7: Perceptions of healthcare services**

| Do ISAW face barriers accessing health care services? | Frequency (N=124/128) | % Percent |
|---|---|---|
| Yes | 114 | 91.9 |
| No | 10 | 8.1 |
| Total | 124 | 100 |

**Table 6.8: Perceptions of police**

| Do ISAW face barriers accessing police services? | Frequency (N=125/128) | % Percent |
|---|---|---|
| Yes | 115 | 92.0 |
| No | 10 | 8.0 |
| Total | 125 | 100 |

### 6.6.2. Crisis care of ISAW

ISAW encountered barriers in service response when seeking to increase their safety in situations of IPV. Participants had the ability to select a list of multiple barriers in answering the question of what barriers existed for women seeking crisis and practical assistance. The lack of sufficient culturally appropriate training of medical practitioners and police officers was indicated as an important gap in crisis care across communities. Almost 13% of workers described the lack of attention to ISAW safety or language needs as additional challenges. In the case of medical services, frontline service providers articulated several justifications for the existence of barriers, including services that were not trauma informed, a lack of attention to women's physical needs, and a breach of women's confidentiality. In fact, 5% of the workers believed that the breach of confidentiality was a barrier for ISAW seeking services Figure 6.6.

Insufficient funding and the resulting insufficiency or inadequacy of available services widened the gaps in service delivery. Part of the logistics of getting to services or gaining access to services were the lack of transportation and the distance from essential services. A wider gap would be apparent for women living in isolated, rural communities or in general, as women experienced IPV after regular office hours, when only limited services are available.

The lack of clear provincial policies for timely and appropriate referrals to resources and services were further explanations provided by 13% of frontline workers as reasons impacting the safety of ISAW during crisis care. Not believing an ISAW when she disclosed IPV was indicted by 7% of the responses by participants.

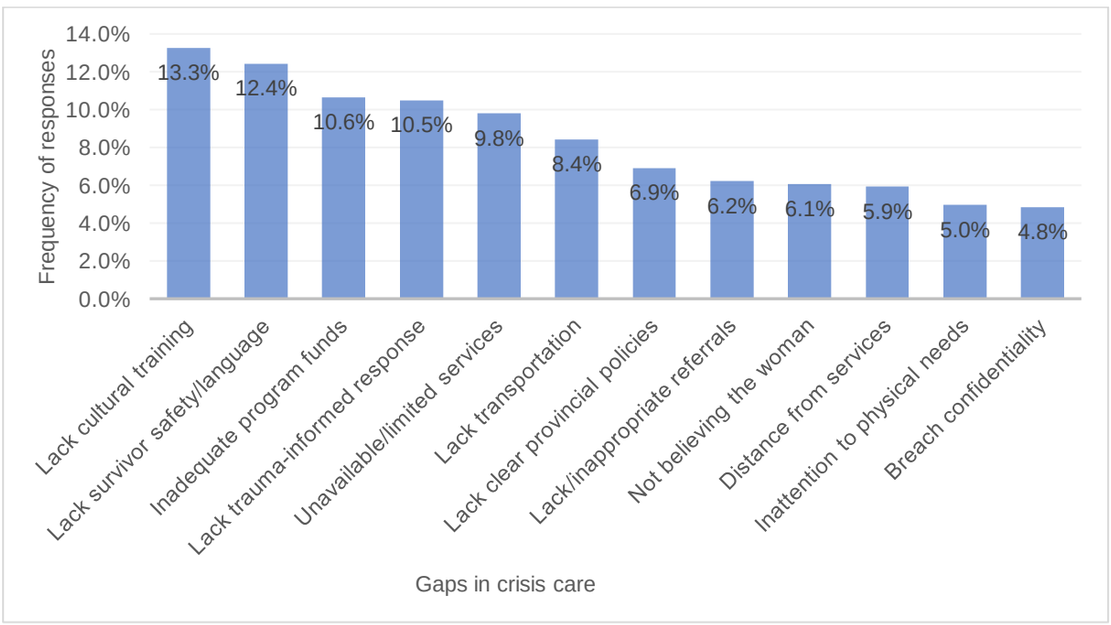



**Figure 6.6: Gaps in crisis care for ISAW**

## 6.7. Gaps to service responses

Despite innumerable challenges faced by ISAW when accessing services within their communities, frontline workers were also confronted with numerous barriers when responding to the needs of ISAW. Participants

pointed out several reasons for the gaps in service delivery when selecting from a list of reasons provided. The lack of language translators or linguistically equipped workers with expertise remained a formidable barrier.

Participants indicated that the limitations included a limited number of the workers with the capacity to communicate in the language spoken by the women and that there was a lack of interpretation services for women who were not fluent in English. This was coupled with other factors such as insufficient crisis care and support, a lack of understanding the culture of ISAW, and the difficulty of attaining medical and police services for their clients. A lack of knowledge and skills when conducting risk assessment for ISAW and assisting with safety planning was an additional factor cited as a barrier for workers in the provision of services to ISAW (4%). Frontline workers (9%) indicated that their clients faced barriers due to the lack of appropriate counselling and crisis support services. Almost an equal number of workers (4%) indicated difficulty ISAW confronted in getting police assistance and medical services. This increased the vulnerabilities faced by ISAW. Workers commented on two other issues they faced: “racism” and concerns of confidentiality of “living in a small town there is a concern the interpreters know the family and this puts stress on the women”. Participants reported the multiple limitations of response services in Table 6.9. Participants were able to tick multiple responses in this question.

**Table 6.9: Limitations to effective service delivery to IPV of ISAW**

| Limitations of response services | N | % |
|---|---|---|
| Lack of workers who speak the language | 90 | 14.3% |
| Lack of interpretation services | 86 | 13.7% |
| Lack of housing options | 77 | 12.2% |
| Inadequate information regarding immigration issues and options to leave abusive relationships | 72 | 11.4% |
| Lack of appropriate counselling and crisis support services | 57 | 9.1% |
| Do not understand the culture of newcomer clients | 44 | 7.0% |
| Difficulty locating legal support | 44 | 7.09% |
| Lack of accessibility to settlement services for newcomers to Canada | 37 | 5.9% |
| Difficulty getting police assistance | 30 | 4.8% |
| Lack of knowledge of community services and supports in the community | 29 | 4.6% |
| Difficulty accessing medical services | 27 | 4.3% |
| Lack of knowledge of risks and safety planning for clients | 25 | 4.0% |
| Total | 630 | 100% |

Additional comments proposed by participants explained the limitations frontline workers confronted and these included:

- Lack of support services to provide culturally appropriate referrals
- Inadequate funding to provide above listed services on a consistent basis

In summary, participants clearly agreed on three critical reasons limiting organisational service response and accessibility to improve service delivery for ISAW in BC. These reasons were the insufficient staff and resources which are required to respond to the demand for services within organisations, and a lack of knowledge and expertise among service providers of a comprehensive understanding of the needs of ISAW. It was also the knowledge of existing services and resources within their communities that would permit the collaboration and coordination of information and services required by ISAW to remain safe and healthy. This is depicted in Figure 6.7.

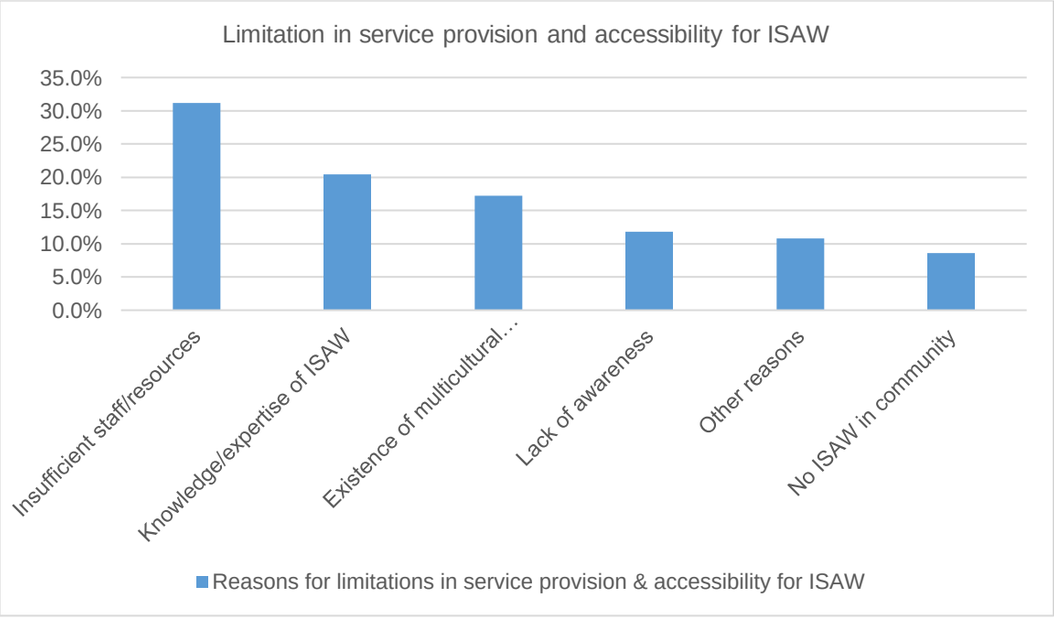



**Figure 6.7: limitations facing service response by organisations**

### 6.7.1. Inadequacy of funding to support response

Almost half of the frontline workers (49%) affirmed that there was inadequate funding for effective service response to IPV, whilst only 3% expressed that funding to support and intervene in IPV of ISAW in their communities was extremely adequate (Figure 6.8). The level of funding affected the capacity of services provided which in turn impacted ISAW's access to these services.

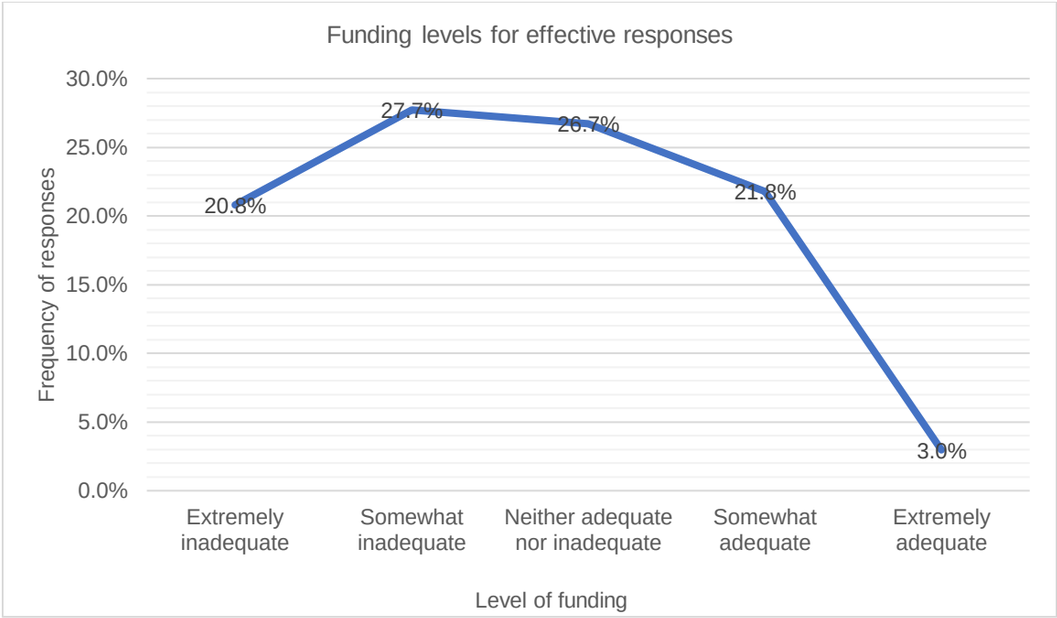



**Figure 6.8: Services funding levels**

### 6.7.2. Healthcare services for ISAW

Frontline workers revealed the specific challenges ISAW faced when accessing medical services for injuries, multiple visits, or emergency services. Participants were able to tick multiple responses when responding to this question. Whilst a number of reasons were noted by workers, (Figure 6.9), the lack of translation services (14%), lack of trauma informed response (14%) and hence, a lack of attention to ISAW safety (11%) and their physical needs (6%) evidently compromised the safety of ISAW. Several factors further contributed to the inaccessibility to medical services such as the lack of transportation, the distance from services and the inadequacy of services where services were either limited or not available. Yet, practitioners not believing ISAW who disclosed IPV (9%), breach of women's confidentiality (7%) and the lack of referrals (8%), were key challenges facing ISAW based on the participant responses.

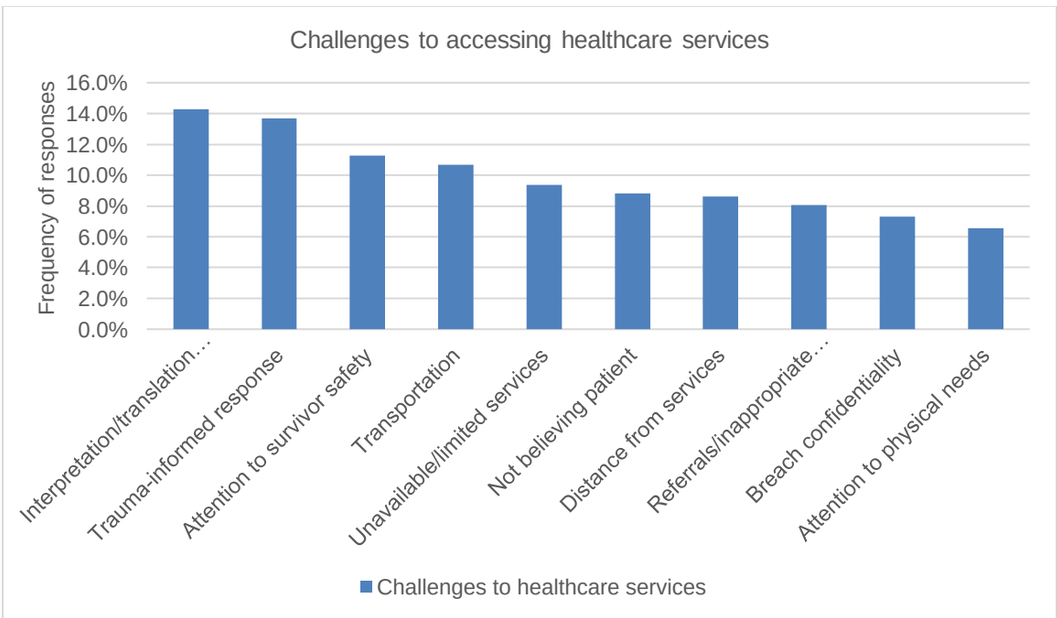



**Figure 6.9: Challenges ISAW face in accessing medical services**

Participants concurred further when providing explanations through their comments. ISAW faced specific hurdles in addition to the ones that were listed in the choices provided for this question. The comments provided by participants included the inability of ISAW to financially afford medical services, insufficient family physicians who spoke their language, and healthcare practitioners' not discussing violence at all.

### 6.7.3. Police protection for ISAW

Similarly, according to participants, ISAW had to tackle numerous challenges when deciding to seek police protection in incidences of IPV (Figure 6.10). The lack of translation services (17%), lack of trauma informed response by police (13%), lack of attention to victim safety (10%), not believing the woman (9%), lack of attention to the physical needs of ISAW (7%) and a breach of privacy or confidentiality (6%), were reported as critical factors. Similar to the factors influencing the inaccessibility to healthcare services, participants agreed that the lack of transportation and the distance from services acted as barriers to seeking police protection. Additional comments by participants included the need for, "the police being informed and exercising their internal policies in cases of IPV such as the "VAWIR policy" [Violence Against Women in Intimate Relationships], pertaining to the charging of the primary aggressor, and "not understanding the culture" see Appendix F).

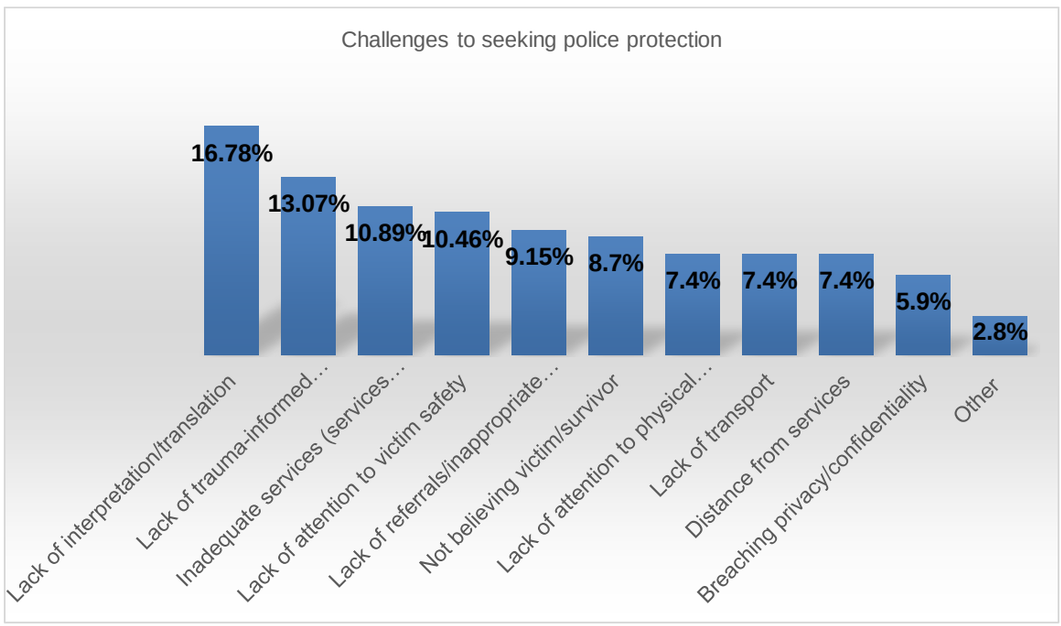



**Figure 6.10: Challenges to seeking police protection for ISAW**

Participants provided open-ended comments on the gaps that existed in communities limiting ISAW accessing police services (Table 6.10).

**Table 6.10: Gaps limiting access to police services**

| |
|---|
| “Gap in appropriate services due to rural location” |
| “Most women experience poor response to male violence from police and state services, its exacerbated when women don't know the language and face racism” |
| “In rural remote communities transportation to the closest facilities with translator is 4hrs or more. As there is no public transportation this in itself is a huge barrier along with no translator outside of the family” |
| “South Asian women do not have full understanding of the laws or the criminal justice system process. When a file opens in the court system, many South Asian women express that it was not what they expected (they thought their husband, the accused, would be taken away for a one time "warning" night)” |
| “We are a rural community and although we do have community services, we are lacking in services provided specifically for immigrant women experiencing domestic abuse. The women I have worked with all rely on their intimate partner/ abuser for their sponsorship” |
| “Delay in Crime Victim Assistance Program (CVAP) application time, lack of funding to victim services to have paid on call after hours - if there is an incident involving this population this may help them understand the police process better and be able to provide safety planning risk assessment etc.” |
| “Police tend to use their own police officers to translate and sometimes this is not sufficient enough. They seem to be reluctant to pay for certified translator” |
| “RCMP do not understand VAWIR policy at all. They often charge both parties in my community!!” |
| “Cultural stereotypes and racist/sexist believes within the system about South Asian women is the biggest barrier. Women from the community are seen as a homogeneous group even though there is a huge diversity and the needs are different.<br><br>There is a need to listen to women and to believe them when they are trying to access legal and health services. Lack of affordable legal services and inability to leave has a huge impact on women's health” |
| “Lack of accessible immigration services in the community”. |

### 6.7.4. Government policies or practices

Determinants for increasing the health and safety of ISAW in BC required effort from all levels of the government (Federal, Provincial and Municipal), according to frontline workers. These specifically included improving immigration policies (14%) and culturally competent training for health service providers and police responders (14%), as depicted in Table 6.11. Participants selected their responses from a list of multiple factors which included policies and services that aided the prevention and intervention of IPV of ISAW. These are culturally competent and integrated healthcare and police services (13%), and access to trauma informed healthcare and police services (12%). Participants were well-aware that service delivery and resource allocations were guided by well-planned and comprehensive government policies and sustainable funding initiatives.

**Table 6.11: Challenging government policies and practices**

| Policies/Practices | Frequency (N) | % |
|---|---|---|
| Immigration policies that protect clients without immigration status or non-residents | 71 | 14.5% |
| Accessing culturally competent training | 67 | 13.7% |
| Lack of culturally competent and integrated services for health care and policing responses | 64 | 13.1% |
| Accessing well-informed and trained police officials | 63 | 12.9% |
| Accessing federal government for assistance | 62 | 12.7% |
| Accessing trauma informed/trained health care services | 59 | 12.0% |
| Policies related to provincial services | 49 | 10.0% |
| Accessing appropriate information about help-seeking needs of immigrant South Asian women | 48 | 9.8% |
| Other | 7 | 1.4% |
| Total | 490 | 100% |

## 6.8. Interventions

The provincial frontline workers recommended interventions based on current practices whilst offering strategies that paved the way for comprehensively coordinated and collaborated efforts for improving the services for ISAW. Many of the interventions weaved the realities that were compounded by the structural, financial and political roles of governments and funders of these provincial and national services addressing violence against women issues. Consequently, the knowledge and experience of frontline workers informed the results of this survey.

### 6.8.1. Strategies and practices to increase accessibility

Explicit interventions were postulated by frontline workers to improve accessibility to healthcare and police services in order to increase the health and safety of ISAW experiencing IPV. The three priorities provided by participants were: making appropriate referrals (18%) in the provision of services, the availability of information relating to services in their communities (17%) and coordination of services (14%), to ensure the existence of seamless service delivery. Figure 6.11 provides more information regarding the other specific interventions suggested by frontline workers. The provision of innovative outreach services such as providing online translation services was an option suggested by respondents.

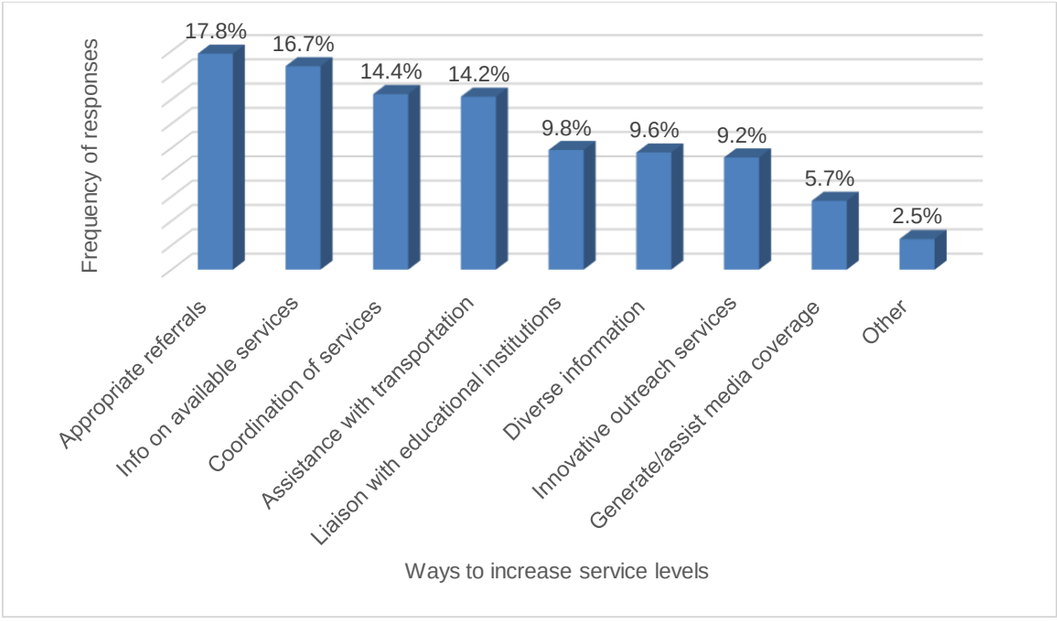



**Figure 6.11: Strategies and practices to increase accessibility**

### 6.8.2. Healthcare interventions to support ISAW

In order to effectively intervene and support ISAW, frontline workers offered clear direction regarding the importance of available translation services and an understanding of culturally appropriate information among service providers (14%). It was the availability of these services that increased the safety for ISAW to disclose IPV without the fear of any breach of her privacy or confidentiality. It was also important to offer emotional support when providing practical assistance to navigate the healthcare system (13%). The healthcare system is a complex system and it remains critical to lend the expertise regarding the next steps for an ISAW. The healthcare services employing trauma informed lens and care (12%) would increase the understanding for appropriate advocacy by these systems. The healthcare practitioner's understanding of the dynamics of abuse, its risks factors and an understanding of coordination and collaboration to increase services to ISAW, remained a priority as shown in Table 6.12. A further awareness and knowledge of community resources for timely and appropriate referrals (10%, 10/100) for women and their children for risk assessment and safety planning were complimentary to their increased health and safety.

**Table 6.12: Healthcare interventions for improving health of ISAW**

| Healthcare Interventions | Frequency (N) | % |
|---|---|---|
| Provide translation and culturally appropriate information | 110 | 13.6% |
| Provide emotional support and practical assistance to navigate the health care system | 105 | 13.0% |
| Provide accompaniment to trauma informed health care services | 94 | 11.6% |
| Provide appropriate information about services in the community, media, places visited by women | 93 | 11.5% |
| Increase collaboration with the health care system | 93 | 11.5% |
| Referral to an appropriate service within your community or elsewhere to provide safety planning | 83 | 10.3% |
| Review risk factors for abuse or violence | 77 | 9.5% |
| Referral to legal aid/services | 77 | 9.5% |
| Referral to child protection (where client has children under 19 years of age) | 56 | 6.9% |
| Other (please specify) | 15 | 1.9% |
| No specific intervention | 7 | 0.9% |
| Total | 810 | 100% |

The healthcare interventions that were commented on included the need to increase collaboration and the training on cultural safety and access to services. Specific comments regarding good practices for medical responses to ISAW included those listed in Table 6.13. Some of the interventions provided included current practices and interventions that worked well in communities and these included “client-to-client partnerships” and pre-arranged advocacy that maintained the privacy and confidentiality of the client during visits to the doctor’s office. Additionally, recommendations included healthcare practitioners asking about IPV despite any disclosure by the woman.

**Table 6.13: Promising practices for medical services**

| |
|---|
| “We have a domestic response team in my small community that will go to any length to ensure a woman feels safe to report, and access supports.” |
| “Having a female interpreter who is trained and experienced in community services and having a strong feminist perspective who is culturally sensitive is very valuable.” |
| “When medical practitioners such as Punjabi speaking social workers make referrals to community-based services.” |
| “We have some Dr’s that will ask us to come in and talk to their patients, when they come in for next appointment. We will already be in the exam room so family members do not find out, that a patient is asking for help.” |
| “We have in the past accessed client to client partnerships. We have had an "existing client", meet w/ "new client" and talk about how services can help, they are not alone etc. This has worked well for both parties.” |
| “Any time a woman attends hospital with injuries they should be safety planning done, questions should be asked about the injuries (not just treat the injury and send them home) even if the woman doesn't disclose abuse but the health care provider suspects it then the woman should be informed of resources.” |

### 6.8.3. Police protection to support ISAW

Figure 6.12 depicts suggestions by frontline workers for increased safety of ISAW. Most importantly, readily available and accessible translation and interpretation services (13%), emotional and practical assistance to navigate the system (12%) and the resources for accompaniment and advocacy in police matters (10%) were critical. Effective referrals for risk assessment and safety planning with the increased collaboration with the policing system remained key to effective interventions. The police responders’ understanding of their own policies such as the VAWIR policy and the primary aggressor policy (9%), relating to IPV situations in conjunction with the identification of risk factors faced by ISAW, were identified as factors that contribute to clarity and minimisation of vulnerabilities women confronted. Another implication denotes the interventions required by police responders to understand the impact of dual arrests (8%), a common situation resulting in the arrests of both the abusive partner and the ISAW, due to the police’ lack of knowledge and understanding of IPV dynamics when applying the primary aggressor policy.

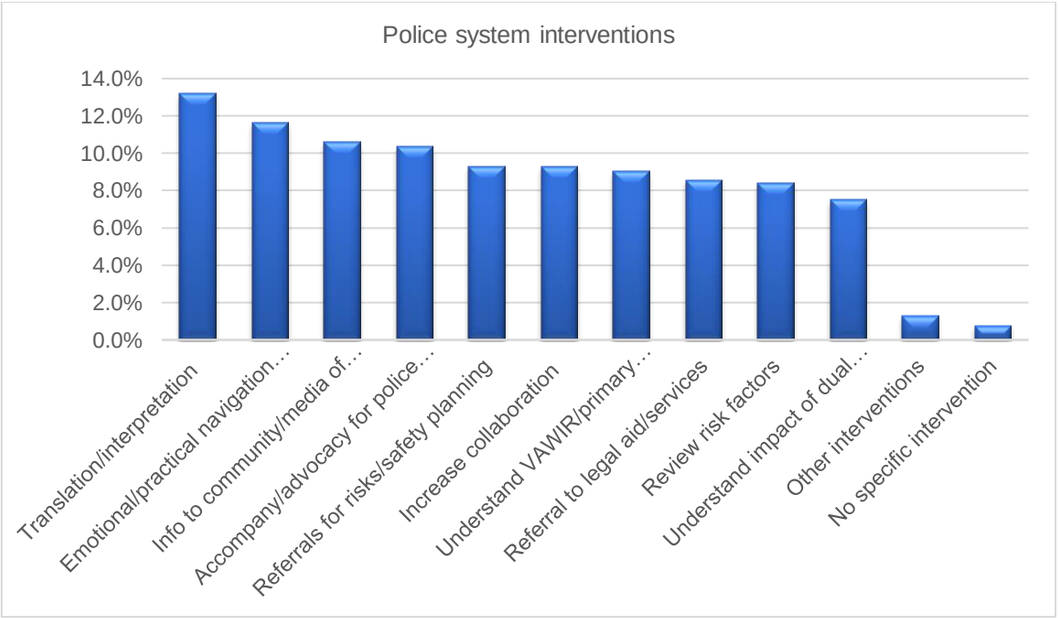



**Figure 6.12: Police interventions to increase the safety of ISAW**

Other interventions suggested by participants comprised the access to related information and services such as justice and immigration services and included the following comments shared by participants in Table 6.14. Improved response by police and the need for training were reiterated as recommendations by participants.

**Table 6.14: Additional interventions to increase access to services and resources**

| |
|---|
| "Produce true information about rights and procedures. The stress and time involved in chasing services that don't really exist (legal aid) and (Canada Immigration and Citizenship) CIC and Service Canada forms that are refused with no reason and take a year to even get a response is inhuman (accuracy of information and the length of time it involves)." |
| "Police response is abysmal all areas need improvement." |
| "Translation independent of someone in the community. Small communities have breaches of confidentiality if the translator is from that community. Intercultural Centers do not fully understand Confidentiality and/or provide information to translators on this subject." |
| "The biggest issue for South Asian women is to trust the family justice system." |
| "Judges and courts needs to be educated to understand the dynamics of abuse of immigrant South Asian women. They need to understand cultural needs and barriers of the victim." |
| "More training for RCMP." |

Frontline workers mentioned that explicit efforts were required to increase the safety of ISAW in their communities and these are shown in Table 6:15. The training issues were reported to address the gender-based biases among police responders, understanding of IPV dynamics of power and control and appropriate referrals for safety and collaboration, are clear recommendations for police service delivery.

**Table 6.15: Efforts to increase the safety of ISAW**

| |
|---|
| “Police willing to have an interpreter present to assist the woman in need.” |
| “There is now more training in domestic violence as part of the RCMP training, and there is still a long ways to go in breaking down gender-based stereotypes.” |
| “When community-based victim services workers work with South Asian women, there is more credibility and voice for the South Asian women to be heard and supported.” |
| “Good practice would be using sensitivity. Always believe the victim and acknowledge the bravery it takes in coming forward. Know how many agencies she may have already accessed. Your agency may also be the very first agency she comes to tell her story or find a safe place, act immediately and with caution.” |
| “Don’t use family members for interpretation/translation. Don't interview victim in-front of family members or the accused. Don't rush the interview, tell her about supports are available. Refer client to victim services. Officers need to be aware of resources in the community so that they fully explain what is available.” |

When participants were asked about ‘best practices’ with regards to police response improvements, a comprehensive inventory of such practices was recommended (Table 6.16). The social systemic response, IPV and trauma informed training, awareness of community services for referrals and understanding cultural dynamics of South Asian families, were considerations for police responders.

**Table 6.16: Promising practices for police responses**

| |
|---|
| “There is not a problem with the police - again it's a systems issue.” |
| “Police willing to have an interpreter present to assist the woman in need.” |
| “Punjabi speaking police officers sometimes attend a Punjabi-speaking household.” |
| “This is a rural community with a high incidence of Royal Canadian Mounted Police (RCMP) staff turnover.” |
| “There is now more training in domestic violence as part of the RCMP training, and there is still a long ways to go in breaking down gender-based stereotypes.” |
| “When community-based victim services workers work with South Asian women, there is more credibility and voice for the South Asian women to be heard and supported.” |
| “Good practice would be using sensitivity.” |
| “Always believe the victim and acknowledge the bravery it takes in coming forward. Know how many agencies she may have already accessed.” |
| “Your agency may also be the very first agency she comes to tell her story or find a safe place, act immediately and with caution.” |
| “Municipal police services are taking it little bit seriously as compared to RCMP.” |
| “I think it is difficult to generalise this for all police personnel but it happens depending who is providing the service.” |
| “The only limitation is the amount of time to organise the translation service to occur.” |
| “Don't use family members for interpretation/translation.” |
| “Don't interview victim in-front of family members or the accused.” |
| “Don't rush the interview, tell her about supports are available.” |
| “Refer client to victim services.” |
| “Officers need to be aware of resources in the community so that they fully explain what is available.” |

Participants were asked to provide additional information of relevance for the health and safety of ISAW that was missed in the survey (Table 6.17). Participants articulated the commonalities that were recommended for both the healthcare and police service delivery which included IPV, trauma informed and culturally appropriate training, the options available for women and sustainability of support services to increase coordination and collaboration among service providers.

**Table 6.17: Additional health and safety recommendations**

| |
|---|
| “More training specific to Immigrant South Asian Women in regards to culture and safety with in their home.” |
| “More specific understanding of the different languages within the culture.” |
| “The language barrier can be huge as can lack of cultural understanding.” |
| “The largest factor that women who come to Canada face is not knowing the extent of the criminal code and the protection in place to support her.” |
| “Some women just want to be heard and supported, yet when an illegal act has happened there is a duty to report which can involve the police, thereby increasing her risk to violence or death.” |
| “We need to work with the client to empower her to make decisions that increase her safety, listen to how we can support her.” |
| “The expenses for these women to fight for their children in court make it very challenging. Women often do not have any income, therefore, without extensive supports from service providers (which, in my experience, are not even adequate), they would have NO CHANCE of having any access to their children.” |
| “Legal services and fees should be available and free. Otherwise, they are discriminated against because they have no money to fight.” |
| “The problem is most often state systems welfare, MCFD (Ministry of Children and Family Development), police they are all woefully inadequate.” |
| “When a Punjabi speaking police officer, interpreter, or victim service worker is not present at the first port of intervention at a domestic violence call, it can be challenging for the woman to disclose the abuse.” |
| “Additionally, if the first interaction that the South Asian woman has with authorities is not positive, she may grow a mistrust towards other professionals such as social workers or victim service workers.” |
| “The immigrant service providers in the community are subject to yearly funding, as is the community-based victim services program.” |
| “Every year we must apply to continue the program. It is always subject to cutbacks. This puts long-term planning and inter-agency planning and cooperation at risk.” |
| “I personally believe the victims feel comfortable accessing community based victims services than police based victim services. Many of these immigrant women have fear of authority and they get very nervous as they hear the word ‘Police’.“ |

## 6.9. Chapter Summary

In this chapter, the results of Phase two quantitative data are presented. In summary, the online survey of frontline workers imparted notable information about the challenges ISAW faced in disclosing IPV and accessing healthcare and police services. The quantitative results provided valuable information, and made it easier to understand the limitations to service delivery across BC. It was not only the knowledge of IPV, its risks to health and safety, but also coordination and collaboration of efforts that was required to bridge

the gaps in translation of services, policies and practices. Frontline workers articulated the difficulties ISAW faced accessing both healthcare and police services due to the complexity of IPV situations and the resulting isolation based on their linguistic and socio-cultural hurdles. The service responses, on the other hand, remained restricted when ISAW did reach out for their health and safety but only to be confronted with a lack of funding, resources, knowledge of responders of the risks they faced and an understanding of their own policies and practices that were in place. The gaps and suggested interventions for both the healthcare and police practitioners were congruent with the perceptions of frontline workers and informed by their practical assistance of ISAW within their communities. The results imparted through the survey will inform Chapter 7.

# Chapter 7. Discussion

## 7.1. Introduction

This study examined the gaps and challenges faced by ISAW in BC from a variety of perspectives, in an effort to understand the health and safety of ISAW accessing the healthcare and policing systems in relation to IPV. Participants included: the ISAW who had left their abusive relationships, key informants, and provincial frontline service providers. The immigrant South Asian community of BC is the largest outside of the Indian subcontinent (Hudon, 2016).

Although BC has policies and services to address the safety of immigrant women over the years and, more is available in the literature, ISAW continue to sustain serious injuries and face homicides. South Asian women have been projected to be the largest growing group of visible minority immigrant women in BC (Hudon, 2016). Therefore, it is critical to address the key determinants of health and safety of ISAW experiencing IPV.

The results of the current study have been reported in detail in Chapters 4, 5 and 6. The data were analysed and interpreted to extrapolate a meaningful understanding of the women's voices. The data allowed the exploration of in-depth experiences of the survivors, their journeys, challenges they faced and the identification of strategies to improve the healthcare and police service delivery, policies and practices. The online survey of provincial frontline responders, focus group of service providers and the key informant interviews provided rich data that were based in their several years of experience serving survivors and influencing policies and practices in the area of IPV in BC. They were able to provide insightful perspectives in gaps and make recommendations to impact the increase of health and safety of ISAW in BC. The help-seeking and disclosure of IPV to healthcare and police responders was compared in order to understand future interventions based on current situations of ISAW. Participants were asked for extended responses to some questions. They are reported as narrative and within tables and graphs and support the robust qualitative results of the focus groups and semi-structured interviews (Fallon, 2016). The integration of the women's voices and that of the practitioners informs the discussion in this chapter. The chapter is a discussion of the integrated findings of both the qualitative and quantitative results.

Healthcare providers and police response are two vital first contact opportunities for the health and safety of ISAW experiencing IPV. In summary, well-informed and trained practitioners and responders are critical to recognising the signs for IPV and providing appropriate and timely assistance and referrals. Missing the opportunity to respond can result in repeat, serious life-threatening injuries and/or lethal consequences for ISAW and their children. The current reality of COVID-19 emphasises the need for social change that influences the incidence of IPV, while heightening the concerns for both the health and safety of ISAW. It is during these times when safety nets and both formal and informal supports are limited, restricted or unavailable for women.

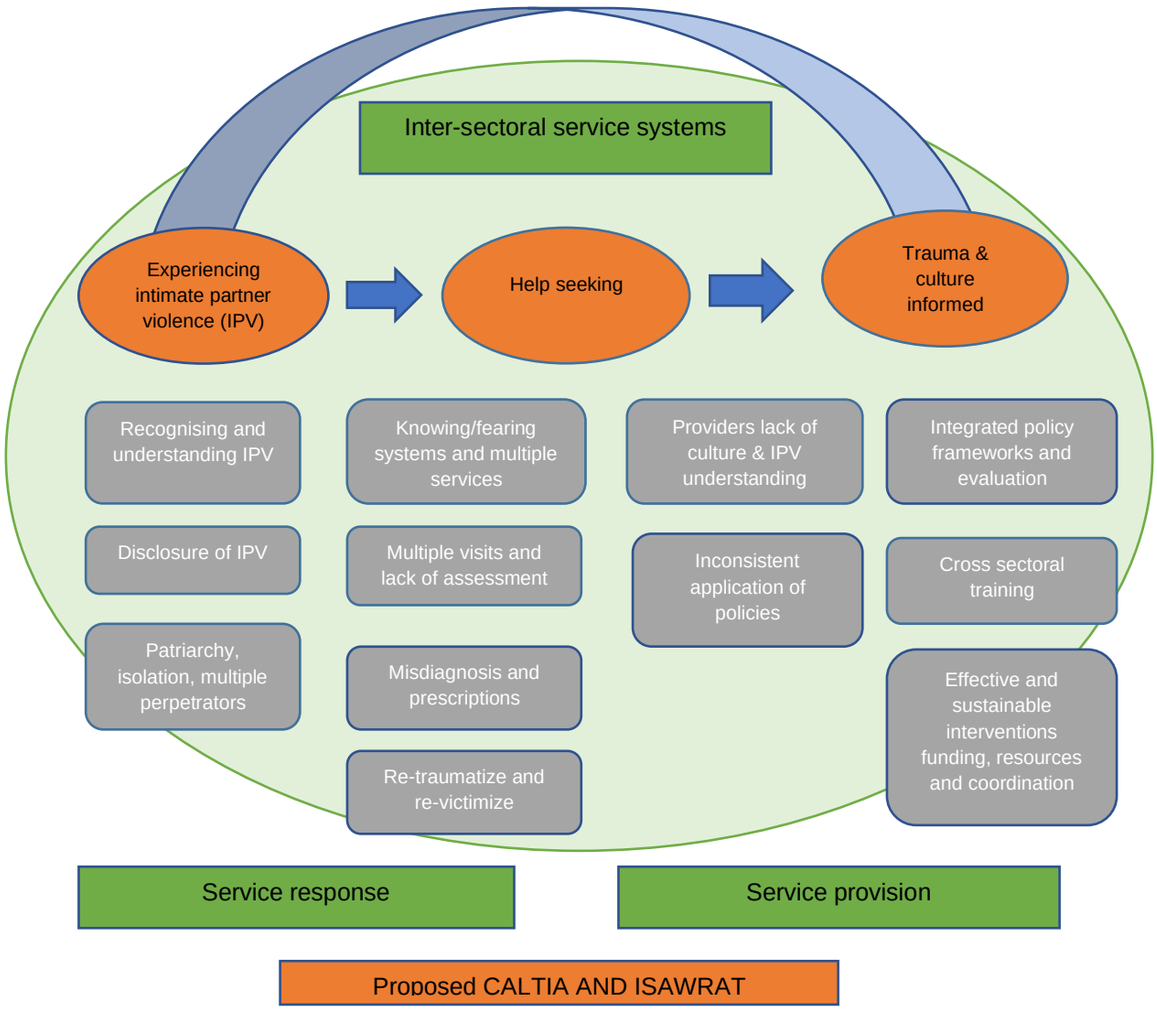



**Figure 7.1: Overall findings of the study**

Figure 7.1 above provides an overall depiction of the findings of the study. The intersectoral service systems of service response and service provision are key components of ISAW remaining healthy and safe. The intersectoral services comprise of service response that needs to recognise and understand the experiences of intimate partner violence (IPV) of ISAW that influences their help-seeking in situations of IPV and the healthcare and police service provision that requires it to be trauma informed and culturally aware. In Figure 7.1, CALTIA – refers to the proposed framework of the Culturally and Linguistically Trauma- Informed Approach and ISAWRAT to the Immigrant South Asian Women Risk Assessment Tool, both of which result from the findings of this study.

## Intersectoral Service Systems

The intersectoral service systems refer to the holistic influences, (the green circle in Figure 7.1), that would improve the health and safety of ISAW to IPV. Intersectoral services systems encompasses service response and service provision by healthcare and police practitioners and is depicted within the green circle of the intersectoral services. Service response impacts ISAW experiencing IPV and their help-seeking of healthcare and police services. Service provision can be enhanced based on the findings and recommendations of this study by employing trauma and culturally informed services that can augment the service delivery of healthcare and police services. The proposed framework of CALTIA and ISAWRAT, (orange rectangle), are derived from the results of this study. It complements the intersectoral service

systems and would enhance healthcare and police service delivery to women experiencing intimate partner violence.

ISAW experiencing IPV in this study were influenced by the following factors (orange circles):

- Recognising and understanding IPV
- Disclosure of IPV
- Patriarchy, isolation and multiple perpetrators

Their help-seeking behaviour was hindered by:

- Knowing/fearing systems and the multiple services they had to navigate
- Multiple visits to receive healthcare services and/or involve the police for protection and the lack of assessment
- Misdiagnosis of IPV signs and prescriptions
- Re-traumatise and re-victimise
- Providers lack of culture and IPV understanding
- Inconsistent application of policies

The recommendations by all the participants in this study articulated a need for trauma and culture informed services which included:

- Integrated policy frameworks and evaluation
- Cross sectoral training
- Effective and sustainable interventions

## 7.2. Experiencing intimate partner violence (IPV)

### 7.2.1. Recognising and understanding IPV

Understanding and recognising the contributing factors to IPV circumstances in a timely and appropriate manner by healthcare and police responders can aid the reduction and prevention of potential injuries and safety breaches suffered by ISAW (Bhandari, 2018; Mahapatra, 2012;). Similar to other research conducted on immigrant women, the identification of risk factors by healthcare and police responders are documented as important indicators in preventing and reducing the incidence of severe injuries and homicides (Campbell et al. 2003; Messing et al. 2013; Sabri, Campbell, & Dabby, 2016). Correspondingly, ISAW in the current study, acknowledged the intricacies they encountered in identifying the signs of IPV. Healthcare and police responders related comparable challenges to the identification of IPV situations as well.

According to the literature, ISAW in North America failed to recognise signs of IPV due to socio-cultural values and beliefs that are positioned in their roles and responsibilities within the dominant patriarchal family structure (Ahmad-Stout et al., 2018; Srinivasan et al., 1998). This was also consistently recounted by ISAW when expressing the length of time it took them to understand that what happened to them, which was indeed IPV, and that that type of assault is a criminal offence in Canada. More importantly, it was necessary to have culturally supportive policies, consistent practices and safety measures in place, to support women (Sabri et al., 2018). The knowledge of their rights and Violence Against Women policies were undeniably applicable to their situations and yet unknown to many of the women.

The delayed identification and recognition of the IPV related risks to their health and safety was clearly evident in the discussions with ISAW. These risks were further heightened by their socio-cultural norms, and beliefs (Hyman et al. 2011; Sabri et al, 2018; Stith et al. 2004; Tonsing, 2016). ISAW reported that they stayed in dangerous IPV circumstances due to their considerable fear of the threats, or incidences of increasing severity and frequency of abuse they experienced. This fundamental and ongoing concern is consistent with literature on both immigrant and non-immigrant IPV survivors (Campbell et al. 2003; Messing et al. 2013; Sabri et al. 2016, 2018).

### 7.2.2. Disclosure

Self-disclosure is a concept that was developed by Canadian Human Psychologist, Sidney Jourard (Jourard 1958, Jourard & Lasakow, 1958). It refers to communication where a person shares information about oneself. Such information may be sensitive and intimate. The concept of self-disclosure was then adopted in nursing by Dr Bonnie Duldt (Duldt 1991, Duldt & Giffin 1985). The theory describes self-disclosure, trust and feedback as the three, central means of interpersonal communication (Eustace & Ilagan, 2010). The attitudes and reactions of healthcare practitioners, including nurses, can hinder disclosure of IPV resulting in secondary victimisation due to treatment related to only the physical injury without further assessment of mental health or emotional concerns (Catallo, Jack, Ciliska & Macmillan, 2013; Inoue & Armitage 2006; Liebschutz et al. 2008; Tower & McMurray, 2006).

A multitude of elements constrained the reporting of IPV by ISAW. Reporting rates vary regarding the incidence of IPV among women across the world. According to a WHO multi-country study, with the inclusion of physical or sexual violence or both, these rates range from 15% to 71% (Bhandari, 2018; Garcia-Moreno et al., 2006).

Contrary to earlier studies of South Asian women (Gill, 2004; Thiara, 2010), some ISAW found the strength to leave relationships despite the numerous barriers confronted, and were supported by informal and formal culturally-competent community and professional services, to re-establish their lives free from violence, stigma and guilt. This also suggests that ISAW, in the current study, attained personal independence to re-establish their lives free from violence, which is consistent with recent research (Bhandari, 2018).

In contrast to studies (Mahapatra & DiNitto, 2013) in which ISAW with children were less likely to leave IPV situations, ISAW – in the current study, were more in line with the findings of Bhandari, (2018) where ISAW left IPV situations primarily to ensure the safety of their children. Therefore, the safety of their children provided impetus for ISAW to leave their relationships. Although ISAW acknowledged the impact of stigma and shame resulting from the breakdown of their marriage, or the financial constraints of leaving the abusive relationship, the safety of their children was imperative for them and aligned with their responsibility as mothers. This notion of safety and their sense of responsibility concurs with the study by Bhandari, (2018) and research completed with non-immigrant IPV survivors (Bhandari, Bullock, Anderson, Danis & Sharps, 2011).

What was new in the current study was the frequency and severity of repercussions and threats encountered by natal family members of ISAW in BC. Evident here were the risks to the safety of natal family members encompassing verbal threats and serious injuries. Although this was not the focus of the current study, ISAW articulated their concerns for the safety and well-being of natal family members both locally and back home. Indeed, BC has had multiple homicides of women and their natal family members. For example, on Good Friday in 1996, Rajwar Gakhal – a 25-year old ISAW, and eight of her family members, were gunned down by her estranged husband, Mark Chahal (30 years old). This unfortunate incident is known as the 'Vernon BC massacre'. Mark fired 28 shots and later shot himself in a nearby motel. Rajwar had reported IPV to the police and filed formal complaints of the threats she received. Rajwar, who spoke English, had resided in Canada for 20 years and did seek police protection by reporting the IPV, but became a victim of homicide along with other supportive members of her family. As a result of the BC Coroner's Inquest, several recommendations were made to ensure policy development to ensure the safety of all women in BC, including the police response adhering to the Violence Against Women in Relationships (VAWIR) policy (Light et al, .2008).

Similarly, in 2007 in Oak Bay, BC, another immigrant woman, Sunny Park, along with her six year old son, Christian Lee and Sunny's parents, Kum Lea Chun and Moon Kyu Park, were fatally stabbed to death by Peter Lee, her estranged husband. Peter later killed himself. Likewise, Sunny spoke English, was a resident of BC and had sought help from healthcare, police and multiple community support services. Once more, the BC Coroner's Inquest found that there was the lack of coordination and collaboration that left Sunny and her family vulnerable to her abusive partner (Turpel-Lafond, 2009).

This is contrary to the study by Yoshioka et al., (2000), which reported that ISAW delay seeking help from their natal families to avoid any interference due to socio-cultural constructs. In fact, it is fear for their safety that ISAW delayed seeking help and disclosing in some instances. ISAW echoed this fear of not just their own safety but also that of their families, both locally and far away in their homelands. These threats and danger to them and their families remains real and often remains unreported and undocumented. It is this fear that makes it difficult for ISAW to leave the IPV situations and continue living with the fear. The danger to the lives of ISAW and their families is apparent and heightened when the natal families are, in fact, supportive of them separating from their abusive partners. This concurs with studies (Campbell et al., 2003; Sabri et al., 2018) that warn of the increased risks for women when they separate from an abusive partner. ISAW, in the current study, remained cautious and continued to live in fear while seeking help because they feared that separation or leaving their abusive partners would increase their risk of injuries and lethality.

### 7.2.3. Patriarchy, isolation and multiple perpetrators

ISAW were aware of the socio-cultural factors that delayed their help-seeking and disclosures to health and safety services, which is similar to previous studies, (Bhandari, 2018; Mahapatra, 2012). ISAW in BC were further marginalised as a result of their migration status based on their sponsorship, financial reliance on in-laws, a lack of understanding and knowledge of resources and services, and the expectations of South

Asian women as keepers of family honour. Research identifies that ISAW and women in general who are not financially secure do not seek help from systems (Gillis et al., 2006). ISAW, in the current study, further expanded the obligations of their arranged marriages and reported living with their in-laws and were expected to contribute to the financial needs of the family unit which is consistent with previous studies (Bhandari, 2018; Gill, 2004; Mahapatra, 2012). In some instances, they were even expected to pay for their initial travel to Canada. This also increased the social isolation ISAW experienced as new immigrants to BC. ISAW were disadvantaged due to their lack of social support which included friends, family and relatives, often in their homelands. Isolation, a common behaviour employed by abusers in IPV to exercise power and control over women, results in low self-esteem and self-confidence which mitigates disclosure of the abuse and help-seeking (Gill, 2004).The social isolation was also endured by ISAW in the current study.

The common existence of multiple perpetrators negatively contributed to the vulnerabilities experienced by ISAW survivors of IPV. ISAW were abused by mothers-in-law, fathers-in-law, and siblings-in-law. The silence and non-involvement of relatives or extended family members were additional factors that were key in the experiences of ISAW in BC. The recognition of societal and familial values and beliefs kept ISAW feeling stigmatised and constrained and these were key to their increased health and safety risks. Several studies confirmed the existence of violence perpetrated by in-laws within South Asian families (Fernandez, 1997; Hyman et al., 2011; Mehrotra, 1999; Bhandari-Preisser, 1999; Watts & Zimmerman, 2002). Although ISAW in BC faced similar circumstances with regards to the existence of multiple perpetrators, the multiple types of abuse to which they were subjected have not been clearly documented in the literature pertaining to ISAW in BC.

The ISAW stipulated additional evidence on the multiple types of abuse they endured, not only from their mothers-in-law but also being subjected to serious assault by fathers-in-law. Brothers and sisters-in-law participated in the abuse or were silent witnesses to the abuse by other family members, including their partners. There was a further dissimilarity to early research by Fernandez, (1997) and Bhandari-Preisser, (1999), where servitude was primarily exercised by mothers-in-law. ISAW in this study expanded this notion of servitude to their partners, and that of other members of the marriage family. It was the increased frequency, multiple types and severity of the abuse that was reported by ISAW that remains distinct and unique to the current study. In addition, the non-inclusion of the risks of abuse by multiple perpetrators has not been clearly articulated in risk assessments for ISAW in BC.

## 7.3. Help-seeking

Help-seeking, on the other hand, has been understood as a coping mechanism to deal with the trauma associated with IPV (Kemp, Green, Hovanitz, & Rawlings, 1995; Mengo, Small & Black, 2017; Mitchell & Hodson, 1983). A much smaller number of ISAW sought medical attention due to an injury related to IPV and required formal support from healthcare and police in addition to other professionals (Ahmad et al, 2013; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003; Raj & Silverman, 2002; Satyen, Piedra,

Ranganathan & Golluccio, 2018). Indeed, ISAW survivors communicated their healthcare concerns and injuries to friends, relatives or in some cases, to their mothers, where they sought emotional and practical support from their mothers who may not have been in the country at the time.

Healthcare and police policies relating to IPV were not applied consistently, making it difficult for ISAW to disclose and, as a result, re-victimising and traumatising them. One example of this was the police primary aggressor policy, (see VAWIR Protocol, Appendix F), where inconsistent or not applying the policy resulted in dual arrests, (where both the survivor and perpetrator are arrested) and denying women the support services and further deterring them from seeking help. This was apparent in both the fatal cases of Rajwar Gakhal and Sunny Park. The lack of consistent, coordinated and collaborative policies caused the ongoing existence of homicides and serious injuries among ISAW in BC, as well as contributing to the homicides of natal family members, despite proactive help-seeking and disclosures by both Rajwar and Sunny as exemplified by their interactions with multiple systems, including healthcare and police (Light et al., 2008). The ISAW homicides feared by ISAW survivors in the current study were shared and confirmed by service providers and key informants, acknowledging the lack of homogeneity of ISAW women, with varying levels of education, language capacity, and length of time living in Canada. This was in contrast to previous studies of ISAW across Canada where the factors that distinguished ISAW were their recent migration to Canada (Ahmad et al., 2009; Mason et al., 2008).

### 7.3.1. Knowing/fearing systems and multiple services

Stigma, shame and guilt contributed to the silence by ISAW, obstructing efforts to disclose the abuse to healthcare practitioners when opportunities arise in interactions with medical professionals (Bhandari, 2018; Mahapatra, 2012). These experiences were similarly expressed by ISAW when they spoke of their responsibilities and the reasons why they continued to remain in abusive relationships, while exposing themselves to increased risk for injury, health implications and lethality. Whether it was socio-economic, or socio-cultural realities of ISAW, disclosing IPV experiences to formal support had further hurdles that they struggled with such as, the attitudes of responders, navigating multiple services, hurried diagnosis, pharmaceutical prescriptions or the lack of culturally sensitive and competent skills.

Similar to the study completed by Yoshioka et al., (2000), ISAW did not readily disclose IPV to health practitioners. However, when ISAW made the effort or gained the courage to seek help, they were confronted with multiple barriers to disclosure including the lack of cultural sensitivity and competency of healthcare practitioners.

Discussions revealed that ISAW were intimidated and afraid to seek services from healthcare, police or community social services. In cases when women are referred by their doctor to community social services, having a name to contact creates trust in disclosing IPV that can be very helpful in facilitating the referral process (Feder et al., 2006; Kelly, 2009). This is only possible when healthcare practitioners are well-informed of the community resources and can make appropriate and timely referrals.

ISAW admitted to psychiatric wards due to the impact of IPV, and expressed uncertainty and fear of not knowing what will happen. Moreover, stigma related to mental health is very real for people from culturally and linguistically diverse backgrounds (Cross & Singh, 2012). It was a concern to participants that no effort was made by hospitals to identify the IPV signs and follow up with referrals to community social services, including transition houses, for supporting ISAW. When IPV is not identified and the related health issues and concerns are missed, the medical attention women receive is further compromised. This leads to the silencing and stigmatising of ISAW. In addition, even well-intentioned healthcare practitioners, including social worker's quick response in calling the police, could increase the risk to the woman's safety and that of her children without safety planning and appropriate supports in place. Based on a paper reviewing the mental health service delivery in Australia with culturally diverse communities, it similarly concluded that the needs of this population remain unmet and called for culturally and linguistically appropriate and sensitive communication between the patient and the clinician, while acknowledging the variation in the expression of symptoms and attempts to seek help (Cross & Singh, 2012).

Previous negative experiences or knowledge of others' dealings with police influenced ISAW delaying decisions to seek healthcare and police services. ISAW described the mistrust, unfair treatment and the uncertainty and lack of knowledge of what will happen to them, their partner or children, which hindered seeking police protection (Feder et al., 2006; Kelly, 2009; Messing et al., 2015). This was found to be contrary to findings that women are hesitant to seek police assistance due to cultural values and the fear that they will be shunned by their community (Horn, 2009; Shalabi et al., 2015).

Several factors contributed to and supported ISAW's decisions to disclose IPV to informal and or formal supports. These included factors such as the frequency and severity of the abuse, the support and access to resources in their lives, both formally and informally, their knowledge and awareness of community-based victim and multicultural services available, and situations where a neighbour or family member called the police (Bhandari, 2018; Mahapatra, 2012). Consistent with other research with immigrant women, ISAW experienced challenges to seeking help and disclosing IPV as a result of stigma and the lack of formal support from community-based services, healthcare and police responders (Ahmad et al., 2009, Sabri et al., 2018). Nevertheless, ISAW in the current study, described their positive interactions with culturally competent, IPV informed community-based and multicultural services, healthcare and police responders. ISAW emphasised the importance of responders' cultural and linguistic IPV trauma-informed knowledge and competence to make timely and appropriate interventions and referrals.

Women felt disheartened that they lived with the false hope of their spouse becoming non-abusive, which contributed to their delayed decision to seek help or leave abusive relationships, in addition to the stigma and lack of support (Ahmad et al., 2009**)**. Yet the hope of regaining their lives and self-identity was important to women (Ahmad-Stout et al., 2018). The hope that their situation would improve was consistently referred to by ISAW as one of the reasons they stayed in their abusive relationships as long as they did. This hope was further augmented for ISAW by the lack or inaccessibility to formal and informal supports (Shalabi et al., 2015).

### 7.3.2. Multiple visits and lack of assessment

Multiple visits to seek healthcare and safety services were attributed to be these systems working within 'silos' – concentrating their efforts with their individual systems (Jordan et al., 2016; Williams et al., 2013). Despite efforts in both systems to address and adapt to meeting the needs of ISAW, the collaborative and coordination nature of these systems remains restricted. Another essential system for participants is community-based services, which provide an advocacy and support system for ISAW, to acquire the knowledge of resources, what happens following a disclosure or reporting to the police, and the repercussions they and their children could face prior to making a decision to take the next step. Community-based services provide an avenue for ISAW to chart their journey with risk assessment and safety planning in place, in addition to having advocacy in place (Sabri et al., 2018). Both the women and key informants stressed that this support is fundamental.

The lack of, or poor IPV risk assessment, increased risks to the health and safety and the growing populations of ISAW in Canada (Hudon, 2016) and is shared by similar trends in the US, (Messing et al., 2013). It suggests the critical need to identify IPV, while acknowledging the specific culturally appropriate and, more crucially, the timely risk identification, assessment and coordinated and collaborative support services. Research studies continue to acknowledge the small-scale and limited research relating to IPV of ISAW, with a particular focus on the existence of serious injuries, health implications, lethality and occurrence of incidences of violence (Messing et al., 2013; Sabri et al., 2018).

The necessity for ISAW to identify IPV related signs and risks is critical, based on the work of previous studies (Heise, 1998; Krug et al., 2002; Sabri et al., 2018; Stith et al., 2004). This confirms similar results in the current study; patriarchal, traditional beliefs and values of ISAW in identifying IPV, results in delays in seeking help, coupled with social isolation, due to the migration factors. To this extent, immigrant women experiencing IPV confirm the increased level of isolation as compared to non-immigrant women experiencing IPV (Amanor-Boadu, Messing, Anderson, O'Sullivan, & Campbell, 2012; Sabri et al., 2018).

The strength of the current study is that it provides the results for the risk factors affecting ISAW and for the preventive strategies suggested by ISAW survivors and the key informants and frontline crisis responders. Hence, the strength of the current study was accomplished by drawing on the expertise of ISAW survivors, provincial frontline service responders and the key informants, which provided extensive and unique perspectives of the current research study's aims and, in turn, enhanced the study's trustworthiness. The results of the current study complements the previous research work (Campbell, 2001; Messing & Campbell, 2016) done in risk assessment, and improving the health and safety of immigrant women by providing pertinent information to improving the health and safety of ISAW and service delivery.

Healthcare and police systems remain key to ensuring the health and safety of ISAW. The interconnections between the multiple factors affecting ISAW such as, race, socio-culture, economic realities, immigration status, and language barriers, need to be understood within the context of cultural norms, perpetuating inequalities in gender and the stigmatisation of women leaving their abusive situations.

### 7.3.3. Misdiagnosis and prescriptions

Many women and their partners consult the same doctor. ISAW face barriers to safely disclosing IPV in such healthcare settings. In some cases, the doctor's response to a disclosure of abuse is simply to prescribe medication for depression. Key informants suggested more referrals for counselling to obtain appropriate and informed support around the experience of abuse. Doctors and healthcare practitioners often have limited time to ask questions and, therefore, focus on physical symptoms presented. Paying attention to indicators of mental health is also critical. This, of course, relates to the time doctors and hospital staff are able to spend with patients given how busy healthcare environments are.

Effective IPV interventions for healthcare and police responses for ISAW were discussed and these were extremely useful in providing clarity and articulating best policies and practices (Ahmad-Stout et al., 2018; Bhandari, 2018). Participant responses revealed a consistent emphasis on the critical importance of first contact for ISAW when disclosing IPV to community social services, healthcare and police. Positive first contact experiences have enormous potential to improve the women's health and safety and nurses often remain a key component in the recognition of deteriorating health signs of women seeking health services within the context of their work (Cooper et al., 2010). ISAW felt safe and supported when practitioners were well-informed about IPV, culturally sensitive and equipped with information and resources to increase systemic coordination and collaboration of services (Jordan et al., 2016, Sabri et al., 2018; Williams et al., 2013).

Participants expressed that it is very important that responders understand the language within the cultural and IPV context to avoid re-victimising women when they seek to disclose or seek protection for safety. ISAW experiences of shame, racism, or arrest, further reduces their trust in help-seeking. Instead, women decide to stay in highly risky relationships that can result in increased lethality and further comprise their health and safety.

### 7.3.4. Re-traumatise and re-victimise

The clarity around the understanding and, therefore, the identification of IPV remains an ongoing concern for ISAW and service providers in both healthcare and police services. Despite attempts by international bodies such as the World Health Organization (WHO), to provide clarity, the complexity and multiplicity of definitions and terms used to describe IPV contributes to confusion among service providers, particularly within the context of ISAW. It is interpreted within the multiple lenses of different countries and culturally-specific populations (Mason & Hyman, 2008). Furthermore, there are discrepancies regarding the definition and recognition by immigrant women experiencing IPV (Latta & Goodman, 2005; Raj & Silverman, 2002).

The unified and consensual agreed-upon definitions and behaviours describing IPV perpetrated by men resulted in the naming of IPV in 1999 by the U.S. Centre for Disease Control (CDC) and the resulting development of typologies of IPV by CDC and WHO (Mason & Hyman, 2008). These encompass; physical or sexual violence, emotional, psychological violence and threats, deprivation or neglect, leading to a more inclusive definition of IPV.

A further notion to consider when understanding the definition of IPV is cultural contingency. Cultural contingency reflects the varying meanings of IPV across cultures and within cultures (Krauss, 2006; Mason & Ilene, 2008). So much so that in different languages and cultures the single term IPV may not exist and may not even be easily translatable (Mason & Hyman, 2008). ISAW explained how witnessing the tolerance of IPV by their mothers was a reason for their own tolerance and acceptance of the abuse. This resulted in their inability to identify abuse and delayed help seeking. This is consistent with previous research regarding the lack of clarity of the acceptability of different types of abuse across different cultures (Gustafson & Illuebbey, 2013; Kalunta-Crumpton, 2013).

Meaningful messaging imparted and endorsed by government and implemented through policy and practice is critical for response systems addressing the needs of ISAW.

The inconsistency in ongoing and sufficiently funded services and resources such as community-based programs, transition housing, and community awareness programs, contribute to inconsistent and precarious messaging of government and funding bodies. In addition, messaging to healthcare and police services of collaborative and coordinated responses remains an issue. Within each system, consistent messages need to be reflected in an effort to ensure that policies and practices are consistently applied. Hence, portraying a message that reflects that serious nature of IPV on the health and safety of ISAW is pertinent.

### 7.3.5. Providers lack of culture and IPV understanding

The South Asian culture is in general a patriarchal dominant culture although any culture is not a homogenous entity based on the existence of privilege and oppression facing women (Crenshaw, 2012). Therefore, responses of both healthcare and police need to be culturally appropriate and specific to the IPV experiences of ISAW in BC. This is apparent in studies relating to violence prevention and service response (Bhuyan & Senturai, 2005; Mason & Hyman, 2008). Additionally, the interplay of race, gender and immigration experiences need to be understood within the context of cultural norms, perpetuating inequalities in gender and the stigmatisation of ISAW leaving their abusive situations. ISAW explained how they found it difficult to seek healthcare support or disclose to practitioners because their in-laws or partners were present during their medical visits making it difficult and unsafe for them to disclose the IPV. In some situations, family physicians or nurses were also known by the spouse and their in-laws, making ISAW concerned for their confidentiality and safety. This barrier is intensified in isolated rural communities where the smaller community and, the number of families, carried increased the risk of breaches to confidentiality and consequently, safety.

Participants believed that increasing the number of service providers who spoke the South Asian languages was a positive step, but this needed to be complemented with several additional supports to ensure that ISAW were not failed by responders (Bhuyan & Senturai, 2005; Bhandari, 2018; Mason & Ilene, 2008; Messing et al. 2013). Whilst hiring of language specific service providers is important, it is just as crucial for them to be trained in cultural and IPV trauma informed practices. Practitioners are required to be aware

of their own biases. A practitioner of the same culture and one who speaks the South Asian language also requires to be culturally competent and IPV trauma informed. Just as critical is an approach that includes the necessity to evaluate the impact of such training and competencies at all levels including organizational, policy and practice (Curtis & Dreachslin, 2008; Williams & Mohammed, 2013).

As discussed in previous studies, (Sabri et al, 2018; Messing et al. 2013; Messing & Campbell, 2016) having cultural safety training along with IPV trauma informed skills lies beyond a single community and as such South Asian practitioners or multicultural women focussed organizations (Campbell et al, 2003; O'Campo et al., 2008; Soglin et al., 2019). Key informants and service providers discussed the gaps in services and resources and stressed that in BC, ISAW were failed due to the lack of coordinated and collaborative efforts, well-trained and competent healthcare and police practitioners and this should be dependent on the culture, or language competency of a survivor. Having IPV trauma informed training and skills coupled with the cultural sensitivity and competency remains critical (Ghandour, Campbell, & Lloyd, 2015; O'Brien & Macy 2016; Sabri et al., 2018).

### 7.3.6. Inconsistent application of policies

Despite the stark histories of immigrant women and their experiences of the healthcare and police systems, women and service providers in the current study confirmed that policies and practices remain incongruent and there are ongoing areas where services can be improved. The lack of specific risk and safety assessment and safety tools regularly and consistently being utilised by both healthcare practitioners and police in BC, remains as a gap and it concurs with research in the area of safety planning and risk assessment (Davies et al., 1998; Jeffrey et al., 2018). Although there are IPV risk assessment tools, there is either an inconsistent utilisation of the tools or, in other instances, they do not pertain to situations specific to ISAW (Davies et al., 1998; Jeffrey et al., 2018). Service providers and women confirmed that there was no time to assess or ISAW were not asked about the potential for IPV despite multiple visits to healthcare due to injuries or mental health concerns as indicated in the literature (Messing et al., 2016; Sabri et al., 2018). Instead, practitioners were more inclined to prescribe medications for symptoms related to their trauma of IPV. Police response to ISAW calls for safety were also, in some situations, confronted by a lack of the application of the provincial policies' consistency and their failure to recognise the multiple signs of IPV, further complicated by language incapacity by the women (Anitha, 2011; Hyman et al., 2011). It was the inconsistent application of policies and utilisation of assessment that further marginalised women, resulting in increased vulnerability to health and safety risks (Ahmad-Stout et al., 2018; Bhandari, 2018). The situations of dual arrests, (where both the victim and the perpetrator are arrested due to uncertainty), cause the lack of clear understanding of the dynamics and particular experiences of ISAW that increased the barriers in services for ISAW, for both the healthcare and police services.

There is an assumption that women need to disclose the IPV and have the knowledge and capacity to navigate the systems on their own. One participant indicated that there were numerous barriers ISAW

confront as new immigrants, including their level of proficiency in the English language, but also their familiarity with medical and police systems (Bhandari, 2018; Sabri et al., 2018).

Participants spoke about how it is important for systems to focus on prevention as well as intervention strategies. Having coordination and collaborative services is one key area that requires more focus, occurring without comprising the health and safety of the women and their children.

Key informants confirmed the existence of these reactive policies and practices in response to homicides of ISAW. In 1996, the Gakhal family murders sparked a BC Coroner's Inquest that called for greater coordination, within and across, regional police responses. The surge of IPV related ISAW homicides in the early 2000s once again ignited community and policy makers to increase resources and funding for creating awareness and increasing efforts to minimise the risks to ISAW. The VAWIR policy (see Appendix F) and the local coordination and collaboration policies and practices require evaluation and audits to ensure their development and consistent implementation across rural and urban healthcare and police responses. The short-term funding of programs and resources remains problematic in meeting the ongoing needs of ISAW experiencing IPV and requiring assistance to safely leave abusive relationships.

Various descriptions of provincial and system policies despite the low reporting rates tend to meet the general need of IPV survivors, while the needs of ISAW continue to remain unmet by policymakers. One key informant articulated this lack of understanding of the needs of ISAW because of a notion of "*one size fits all*", as well as experiences of racism.

Understanding the specificity of efforts and its application to the development, implementation and evaluation of policies and practices created to meet the needs of all women, fail to be time and culturally sensitive to the needs of ISAW. It takes time to create culturally competent and sensitive policies and often these are developed at a much later time. In the meantime, ISAW remain vulnerable to health and safety risks in IPV situations. Sufficient funding and resources should be dedicated to create policies, practices and training for all women, including ISAW, not as an afterthought. One such service is the availability of trained interpreters for ISAW. Hence, access to trained interpreters in a timely manner is essential (Guruge & Humphreys, 2009).

## 7.4. Trauma and culture informed services

### 7.4.1. Integrated policy frameworks and evaluation

In comparison to rural communities, urban communities have more services and resources that ISAW are able to access, including responders and practitioners who are equipped with the language and are IPV and culturally informed. In several smaller, rural communities across the province, the geographical distance from services and resources limits access while increasing the isolation faced by ISAW and consistent with statistics of a higher rate of isolation faced by IPV survivors in rural communities across BC (Conroy, Burczycka & Savage, 2019). This directly impacts women's timely access to health and safety services.

Therefore, having holistic services based on knowledge and skills to work with ISAW is a responsibility that needs to be developed to ensure their health and safety (Williams et al., 2013; Jordan et al., 2016). Services need to be supportive for women when they disclose and report IPV, and not be silenced by them. Policies and practices supported by research can in turn be complimented with sufficiently resourced and funded services for service provision and education of practitioners (Cross, 2009).

### 7.4.2. Cross sectoral training

Studies in violence prevention and service response (Bhuyan & Senturai, 2005; Mason & Ilene, 2008), recommend they be culturally appropriate and specific to the IPV experiences of immigrant women. While the results of the current study concurred, ISAW provided further insights into the barriers that they faced to remain safe and healthy. Service responders not only had to be culturally sensitive and competent, but responders also needed to be trained and skilled in IPV trauma informed care, in order for practitioners to understand the dynamics, impact, and risks of lethal and serious healthcare consequences for ISAW (Ahmad-Stout et al., 2018; Jeffrey et al., 2018). In cases where healthcare or police responders were not able to assist the ISAW, some were skilled enough to make appropriate and timely referrals with the consent and knowledge of the woman, thereby not comprising her health and safety further.

There are several factors that influence the lack of sufficient attention to understanding IPV at the beginning of their careers, despite concerted effort by both healthcare and police responders to address this gap. Educators and trainers were disappointed that training was merely part of the ‘tokenism’ towards IPV. This is reflected by the small amount of time dedicated to understanding the issue when preparing health professionals for their careers and was continually well-documented in the literature (Campbell, 2004; Jeffery et al., 2018; Lindhorst, Nurius & Macy, 2005).

### 7.4.3. Effective and sustainable interventions

The importance of effective interventions to meet the needs of ISAW was articulated in a number of ways. Effective interventions included IPV trauma informed and culturally appropriate training for all levels of responders and policy makers. It requires dynamic and well-informed policies with clear directives and messaging across services and the larger community, and coordinated and collaborative efforts for improved response to IPV of ISAW. Consistent with studies conducted with ISAW in the US, this study acknowledges that healthcare practitioners play a significant role in providing culturally and IPV trauma informed services and referrals (Gurm, Thandi, Early, Majedi, Menon, Cheema, & KPU Nursing Students, (2013; Gurm et al., 2020; O’Campo et al., 2008; Sabri et al, 2018).

The current study provides an understanding of the challenges and gaps faced by ISAW when accessing healthcare and police services. It is expected that the information extracted from the results will be instrumental in the development and implementation of strategies and interventions of healthcare and police response across BC.

The discussion of the results reported in this chapter reflected the qualitative data from the service providers’ focus group and the key informant interviews, which was related to the extant literature. The

three main themes were service responses challenges, systemic barriers and promising policies and practices. The service response challenges included sub-themes of socio-cultural values and norms, perceptions of responders, response time and balancing cultural and IPV knowledge and skills. The systemic barriers theme included fragmented and under-funded services, reactive policies and practices, falling through the cracks and compromised health and safety.

The policies and practices included coordinated and collaborative services and systems and cross-sectoral culturally and linguistically informed training and competencies to improve the capacity of service delivery. The service providers were clear in identifying the barriers based on their experience in working with the women and understanding the system structures and the policies and practices that impacted the accessibility and appropriateness of the services for ISAW. They were able to inform the current study of the underlying barriers confronting ISAW and the gaps that the system's presented. Policies and practices that were based on an understanding of the challenges facing ISAW, which included their socio-cultural context, were further complicated by the systemic challenges of IPV services being under-funded, reactive to community outcry when ISAW homicides surfaced, lack of timely and appropriate referrals and the biases and stereotypical mind frame of healthcare and police responders.

The disconnected (*"siloed")* systemic responses often prevented the seamless accessibility of services and resources for ISAW, leaving them further silenced and unable to remain healthy and safe. The need for coordination and collaboration of services and resources with an understanding of culturally and linguistically informed training and resources to provide effective services to ISAW, was agreed upon by the service providers. In fact, BC's Provincial Office of Domestic Violence (PODV) was clear to indicate that its objective was, "*to eliminate domestic violence, we must share information, break down silos and work together*" (PODV, 2016, pg. 6).

The key informants presented three main themes related to gaps in service delivery, culturally and linguistically appropriate policies and coordinated and collaborative efforts. The sub-themes included understanding social/cultural constructs and IPV dynamics, policies and practices, systems response and structure, supportive and clear messaging and effective interventions at all levels. These themes and sub-themes provided a macro lens of government and policy maker perspectives of what currently exists and presents as challenges based on an overall provincial VAWIR framework of service delivery and its complexity of meeting the needs of ISAW, as well as possible interventions that can support the health and safety of ISAW across British Columbia.

Although participants provided many examples of the challenges facing ISAW, proactive work in improving the services and resources to ISAW were identified to improve services. Examples of coordinated and collaborative efforts between systems, timely and appropriate identification and, referrals and development of policies and practices with the cultural and linguistic trauma informed knowledge to service delivery, were among the interventions identified to overcome the multiple and complex challenges of IPV for ISAW.

An intervention that would bridge the gap and create a big shift in the way the police system currently responds to IPV situations, is for women and their children to continue staying in their home while the abusive spouse and extended family (if applicable) are removed from the home. A woman who leaves her home to stay in a transition house typically finds herself without access to her house or any of her personal possessions. This is just one reason among many that make it difficult for ISAW to leave abusive situations.

Despite the numerous challenges and barriers facing ISAW, participants were hopeful of future efforts creating positive changes. Robust skills training, and the development, implementation and consistent application of appropriate policies and practices were starting points. A perception shared by all participants was that well-trained practitioners had to be authenticated by resources and systemic integrated, coordinated and collaborative efforts, in order to improve the health and safety of ISAW.

## 7.5. A proposed framework for service delivery

### 7.5.1. ISAW Cultural and Linguistic Trauma Informed Approach (CALTIA)

The current study provides an understanding of the influences affecting the health and safety of ISAW. Figure 7.2 depicts the hierarchy of influences confronting ISAW based on the findings of the study. The socio-cultural values and beliefs of ISAW are further influenced by migration and socio-economic factors affecting them after they arrive in Canada. These include the financial obligations and expectations of their spouses and extended families, and the lack of control and inhered dependence on their spouse. The fear of the threats, frequency and severity of violence is a result of the lack of informal support, knowledge of resources and formal systems. Finally, the inability to recognise, or the denial of IPV, increases the risks to health and safety of women and their children.

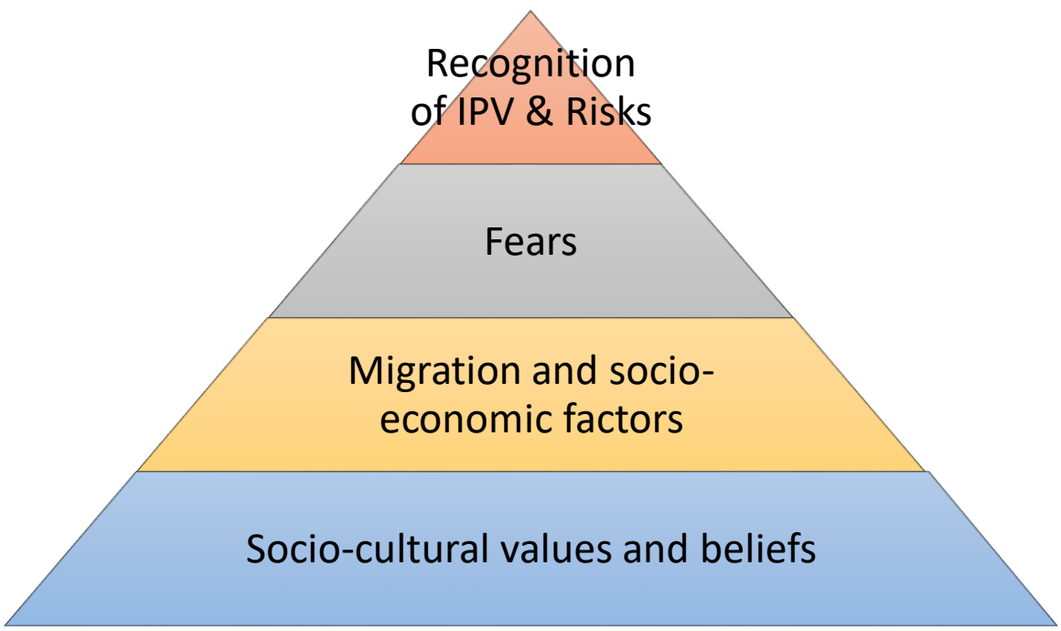



**Figure 7.2: ISAW health and safety influences**

This study proposes a cultural and linguistic trauma informed approach (CALTIA) to service delivery for ISAW by healthcare and police responders in BC (see Figure 7.3) to improve the health and safety of ISAW. This approach was developed based on the findings and understanding gained in this study and will serve to complement the existing Violence Against Women In Relationships (VAWIR) framework currently in use in BC. The CALTIA for ISAW incorporates the VAWIR framework specifically for IPV service delivery. The diagram below (Figure 7.3) depicts the hierarchy of the service delivery approach with regards to the needs of ISAW as informed by the results of the study.

The proposed service delivery approach recommends a comprehensive approach involving the inclusion of South Asian socio-cultural realities into the development and implementation of policy and practice of healthcare and police response. At the centre of the approach is the coordination and collaboration of provincial efforts which supports the ISAW CALTIA service delivery, resulting from the ISAW CALTIA response which, is in turn, guided by relevant policies and practices development and consistent implementation. Figure 7.3 indicates that ISAW CALTIA coordinated and collaborative provincial efforts are essential for the achievement of coordinated and collaborative service delivery. It is this service delivery that would be successful in guiding the response to ISAW. The service delivery response can be further enhanced with relevant policies and practice development and implementation. All the coordination and collaboration will then be able to support the risk assessment and safety of ISAW. For the whole approach to be relevant and applicable for ISAW, it is suggested that it be initiated by the ISAW Risk Assessment Tool (ISAWRAT). The ISAWRAT is a survey for ISAW and was developed based on the findings of this study.

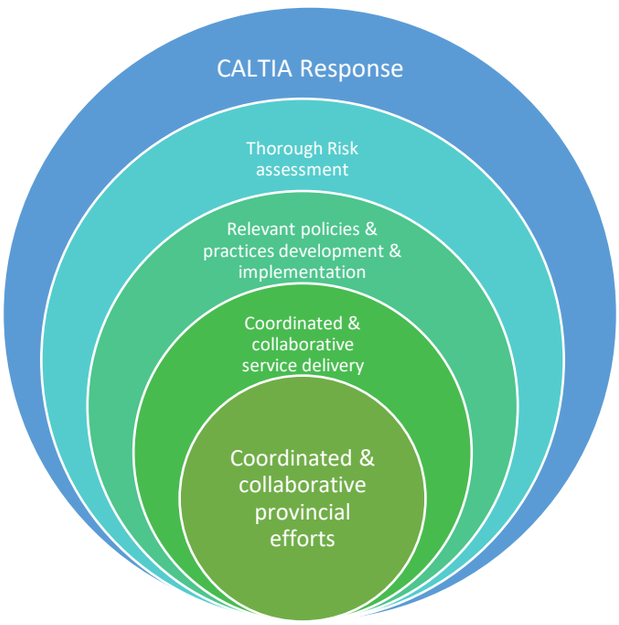



**Figure 7.3: ISAW CALTIA service delivery approach**

### 7.5.2. Risk assessment for ISAW: the ISAWRAT

"*Any risk assessment needs to be considered through the lens of the unique vulnerabilities of each victim. This can only be determined by having the victim, or a victim's advocate inform the process. Subsequently, she needs to be advised of relevant information from risk management plans*" (Campbell, Hilton, Kropp,

Dawson & Jaffe, 2016, pp. 4). Yet it remains important to bear in mind that asking a woman her perception of danger or risk is as good a predictor as any assessment tool and that no single tool is more accurate than any other (Gurm et al., 2020; Hanson et al., 2007).

The increasing population of ISAW in BC and the risk to their health and safety, makes it critical for healthcare and police responders to recognise the challenges facing ISAW. The current study has clearly demonstrated that service delivery needs to be IPV informed and culturally competent at identifying risks, and be mindful of them. It becomes apparent that IPV identification and risk assessment needs to be available for early detection and to reduce serious injuries, health implications and homicide of ISAW. Risk assessment and safety measures have been stressed by researchers in the area of IPV, particularly as it pertains to immigrant women (WHO, 2010; Messing et al. 2013; Sabri et al., 2016, 2018). It is also crucial to note isolation within IPV can be further impacted by ISAW residing in rural or remote communities and support services may be limited or out of reach. This is particularly important as the IPV rates in rural areas is approximately 1.8 times higher than those in urban areas of BC (Conroy et al., 2019).

The ISAW Risk Assessment Tool (ISAWRAT) has been developed based on the CALTIA service delivery approach to provide early identification and detection of IPV and its risks, specifically for ISAW experiencing IPV in BC. The ISAWRAT is a culturally adapted tool to enhance service delivery to ISAW. It is based on the BC Ministry of Public Safety and Solicitor General (MPSSG), Domestic Violence Risk Factors (DVRF) (Appendix F) (EVA BC, 2014). Although the ISAWRAT has not been tested, it is recommended for use in order to meet the needs of ISAW in BC. The ISAWRAT was developed by the researcher in consultation with the research supervisors. The risk factors identified in the ISAWRAT (Table 7.1), were identified as critical IPV signs of risks but were missed or minimised by ISAW in their experiences of IPV, resulting in the increased incidence and severity of IPV.

The ISAWRAT can be easily translated to meet the linguistic and cultural needs of ISAW. It will also enable practitioners working with ISAW to identify, understand and minimise or eliminate the risks of IPV for ISAW through early and timely self-assessment with the aid of the ISAWRAT.

The study informed the specific cultural development of the ISAWRAT (Table 7.1). The study findings indicated the need for a simple, culture and trauma informed IPV risk identification tool for ISAW that included the risk factors identified by the current Ministry of Public Safety and Solicitor General, (MPSSG) Domestic Violence Risk Factors (DVRF). Additionally, ISAWRAT is inclusive of the culture-specific risk factors identified as critical in this study and can aid the early identification of IPV and its risks to the health and safety of the women. Furthermore, an understanding of CALTIA and the application of ISAWRAT can potentially address the significant gaps that healthcare and police service providers expressed, including the limited time, lack of training and knowledge of culturally and linguistically applicable IPV signs and resources, and the failure to apply consistent policies and practices.

The ISAWRAT also supports the early and initial identification of IPV of ISAW by healthcare and police responders, leading to more comprehensive and formal risk assessment and safety planning. Timely and

appropriate referrals can be facilitated with the use of the ISAWRAT when a high level of risk is indicated and, hence, be a step to prevent and minimise the impact of IPV. Evidently, the notion of "*one size fits all*" is not applicable to all women including ISAW. Participants repeatedly echoed the urgent need for both culture and trauma informed policies and practices for ISAW. Hence, the framework offered by CALTIA and the use of the ISAWRAT is complimentary for the health and safety for ISAW in BC.

Some of the factors in the ISAWRAT relate specifically to ISAW. The inclusion of strangling, choking or biting of a woman by other family members, in addition to her partner, pertains to multiple perpetrators and constitutes a risk factor for ISAW. Although the third item is a risk factor for all women, the increase in violence by family members could also increase ISAW risk to violence. Similarly, item four; sexual assault, has been identified as a risk factor in the MPSSG DVRF, however ISAW would better relate to being forced to do things against her will such as having sex. ISAW elaborated accounts of such assaults by their partners and other extended family members such as fathers-in-law. Along similar lines, item five, being forced or being in arranged marriages can contribute to IPV dynamics (MOSAIC, 2015). Item six relates to violence during pregnancy and multiple miscarriages which for ISAW could be the result of their partner or his family's preference for sons. Furthermore, item nine relates to the South Asian cultural practice of living with in-laws after marriage and with the belief that the woman has to serve them, consequently resulting in servitude and violence. Likewise, item ten, having in-laws accompany ISAW for their medical appointments can denote a sign of IPV. Comparably, item eleven, which involves threats to hurt the woman, her children, pets and her family is the reason some ISAW reported delaying IPV disclosure. Item twelve highlights the cultural concepts of stigma, family honour and shame, which are also referred to as the notion of "*saving face"* among family, friends and society, signalling IPV. Item thirteen, which signifies not knowing or fearing of the laws or the authorities, was narrated in the findings as potentially causing an increase in isolation of ISAW and subsequently a risk to IPV.

Overall, the ISAWRAT complements the BC Ministry of Public Safety and Solicitor General (MPSSG), Domestic Violence Risk Factors (DVRF), and incorporates the specific cultural risk factors as they relate to ISAW. It provides service providers a clearer understanding of the culture and trauma informed IPV factors pertinent for the health and safety of ISAW. The ISAWRAT score/response chart lists the sixteen items in their order of importance to risk. It is crucial to note that the ISAWRAT is not a replacement for comprehensive risk assessment and safety planning, it is an additional risk identification aid pertaining to ISAW.

The scores/response guide in Table 7.1 are indicative of the risks to lethality and health concerns pertaining to IPV situations and provides a key for responses by the practitioner. Any IPV incidence or injury is indicative of a health and safety risk and the identification of weighting established for the level of risk has been based on the DVRF and previous research in this area (Gurm et al., 2020; Hanson et al., 2007; Jeffrey et al., 2018; MOSAIC, 2015; Sabri et al., 2018).

**Table 7.1: The ISAWRAT Score/response Chart**

| IPV Incidence/injury | Yes | No |
|---|---|---|
| 1. You have been strangled, choked or bitten (also burnt, broken bones) by your partner or other family members | | |
| 2. You are separated from partner (past, or recently) | | |
| 3. You fear that the violence will increase, and worry about your children and family members | | |
| 4. You have been forced to do things against your will such as having sex | | |
| 5. You were forced/arranged to marry your partner | | |
| 6. You have experienced violence during pregnancy/had miscarriages | | |
| 7. Your partner has access, used or possesses weapons/firearms | | |
| 8. Your partner has mental health issues (depression, paranoia) | | |
| 9. You live with your in-laws and believe it is your duty to serve them | | |
| 10. You are always accompanied by your spouse and/or your in-laws to medical appointments | | |
| 11. Your partner threatens to hurt you, your children, pets, himself or your family if you leave him | | |
| 12. You are staying in the marriage/relationship to “save face”/ keep family honour | | |
| 13. You are new in the country, do not understand the laws and are afraid that you will be deported by the authorities | | |
| 14. You have a disability | | |
| 15. You are an older woman | | |
| 16. You are being sponsored by your spouse in this country | | |

**Table 7.1: The ISAWRAT Score/response Chart**

| Score/response chart | |
|---|---|
| **Level of Risk** | **Suggested Response** |
| High Risk | If Yes is checked for any questions 1 to 7<br>The woman's safety could be at risk. Strongly recommend the following immediate steps are with the understanding and consent of the woman:<br>Call 911<br>Locate and make linguistically and culturally appropriate referrals for risk assessment and safety planning to community/healthcare service close to the woman<br>Ensure the immediate safety of the woman and her children/pets<br>Ensure a safety plan is in place |
| Medium Risk | If Yes is checked for any question 8 to 15<br><br>Provide 24-hour crisis language and culturally appropriate information<br>Provide immediate linguistically and culturally appropriate information and practical support<br>Make linguistically and culturally appropriate community services referrals for safety planning to woman<br>Provide IPV, health and safety services within easy access for woman. |
| Low Risk | If Yes is checked only for question 16<br><br>Provide 24-hour crisis linguistic and culturally appropriate information<br>Make linguistically and culturally appropriate referrals for woman to community services for risk assessment and safety planning<br>Provide IPV, health and safety information within easy access for woman. |

The current study adds to the body of knowledge by providing the ISAWRAT as a means for both ISAW to identify and self-assess IPV, and for service providers to utilise it for preliminary identification and risk assessment of the perceived safety of ISAW. This tool in no way replaces existing risk assessment tools in healthcare and police responses but compliments efforts to increase the health and safety of ISAW in BC. The ISAWRAT provides culturally appropriate IPV identifying factors for ISAW in addition to those suggested in various assessment tools and literature on risk assessment for immigrant and non-immigrant women (Campbell et al., 2003; Messing et al., 2013; Sabri et al., 2018).

## 7.6. Chapter Summary

In summing up, participants concurred that responders need to deliver effective intervention services that are IPV trauma and culturally informed. These require appropriate risk assessments, safety planning, timely referrals, and a knowledge of appropriate community resources for ISAW. Figure 7.1 provides a diagrammatic overview of the findings of the study. It highlights the intersectoral service systems as over-arching for the experiences of ISAW to IPV, their help-seeking behaviours and their experiences of service responses.

The findings drawn from the data analysis have been discussed in this chapter. The challenges of ISAW experiencing IPV require the support of healthcare and police responders to remain healthy and safe from injuries and lethality due to IPV. An understanding of their challenges provided insights into their delayed help-seeking and disclosures of IPV to healthcare and police responders. Therefore, the identification and risks assessment of IPV, specific to the realities and vulnerabilities of ISAW, remain a crucial unmet need in service delivery. Service providers and key informants articulated the importance of integrated, intersectoral coordinated and collaborative policies and practices that play a central role in healthcare and police responses.

Chapter 8 presents the conclusions drawn from the study. The chapter will include an outline of the limitations of the study, recommendations to improve healthcare and police response, and future research into the IPV experiences of ISAW in order to eliminate serious injuries, health implications and fatalities, and ultimately improve their lives.

# Chapter 8. Conclusion and Recommendations

## 8.1. Introduction

The focus of this study has been to achieve its aim of exploring the issues facing ISAW in British Columbia and to understand how service provision by the healthcare and police systems can be improved to meet the needs of ISAW experiencing IPV. The objectives were, firstly, to identify the gaps facing ISAW and healthcare and police responders to IPV of ISAW. Secondly, to identify how services could be delivered in a more supportive and coordinated way to meet the needs of ISAW.

The findings of this study provide critical understanding of the complexity and multi-layered intricacies influencing the service delivery and help-seeking strategies for improving the health and safety of ISAW. Meaningful messaging imparted and endorsed by the government and implemented through policy and practice is critical for response systems addressing the needs of ISAW.

This study examines both the reasons for ISAW delaying help-seeking and their experiences with healthcare and police when they decided to seek help. It involved multileveled attempts to gather information from ISAW who had left abusive relationships and sought help. ISAW communicated what worked and what hindered or delayed their help-seeking beyond their socio-cultural realities. Key informants of policy makers and experienced management community social services, healthcare and police practices and, the provincial service providers, were instrumental in lending their expertise to what prevented ISAW from seeking help and what gaps they faced in accessing services and what challenges stood in the way of service delivery. This is a study which aimed to comprehend a complete picture of what are barriers, what can be improved and how it can be accomplished.

This study is unique in its development of a clearer understanding of healthcare and police response systems in order to improve the health and safety of ISAW. The coordination and collaboration between community social services, healthcare and police remains a challenge. Bridging this gap in services and information will better equip responders to respond to such situations. The findings are informed by ISAW survivors who have navigated both systems and survived to enrich the knowledge of their experience and what improvements can be made to services. In addition, the multiple levels of service providers and policy makers provided insight into the gaps facing ISAW to accessing services, the challenges service providers face in assisting ISAW and what they believe are critical for improving service delivery for the health and safety of ISAW in BC.

The findings of this study have provided many insights into the perceptions of the women and the workers in the community, the healthcare and their belief systems. The four groups of interest in this study have provided rich data, to understand the socio-cultural and systematic barriers raised by ISAW in BC. Each of the groups provided the data with emphasis on specific themes as they related to the group, while the overall findings provided a clearer picture of the pattern of issues and concerns among the frontline service

providers and the policy makers. The research study's trustworthiness was enhanced as the expertise of survivors and diverse practitioners and policy perspectives informed the research aim.

## 8.2. Findings drawn from the study

Several conclusions have emerged from this study. These findings have been listed to include their implications and what is important to resolve them.

1. Self-disclosure by ISAW is hindered by their language skills, a lack of understanding of their rights and difficulties in navigating healthcare, protection and safety systems. An understanding of the barriers, and risks facing ISAW when accessing healthcare and police services can improve the accessibility to these services. It can further influence the improvement in service delivery and dedication of sufficient resources to support the services.

2. ISAW fear of losing their children to their spouses or child protection services and/or their immigration status when making complaints of IPV. An overall understanding of the issues and concerns facing ISAW accessing services related to IPV can better equip healthcare practitioners and police responders assisting them. These include addressing responders' perceived negative attitudes of the South Asian community and ISAW's delay in disclosing IPV.

3. An overall sense of discrimination and racism is experienced by ISAW when accessing healthcare and police services. These experiences necessitate the development and implementation of policies and practices that are intersectoral, culturally appropriate and trauma informed.

4. Policies, practices and training lack an adequate, integrated, and intersectoral approach. An integrated and intersectoral approach should entail a coordinated and collaborative effort in service delivery, demanding timely and appropriate identification of IPV and referrals to community social services for risk assessment and safety planning. Hence, coordinated, collaborative, and integrated approaches to service delivery should be central to the policies and practices pertaining to IPV, particularly for ISAW.

5. Concerns expressed relate to breaches of confidentiality, or the fear of it, when ISAW contemplate seeking help for health and/or safety concerns for themselves and their children. The importance of culturally, linguistically and trauma informed training, education, policies and practices remain central for police response and healthcare service delivery. These concerns draw attention to the significance of IPV identification, knowledge and ISAW specific accessible resources to decrease the social isolation of ISAW due to IPV dynamics and culture. It compels early identification of IPV, risk assessment, safety planning and referral to appropriate services by healthcare and police responders.

## 8.3. Key recommendations

Several recommendations can be drawn from the exploration of the experiences of ISAW who experienced IPV in this study. It provides a comprehensive understanding of improvements that can be made by healthcare and police services in minimising and preventing their risk to injury and lethality.

The insights provided by service providers and experts in the area of IPV drew attention to missed opportunities in healthcare, clinical practice and police response in recognising IPV signs and risk assessment. These missed opportunities were often a consequence of the cultural identity of the women, and their own professional cultural attitudes and perceptions towards the women and IPV in general.

This study adds to the existing literature by offering recommendations that pave the way to increase and improve the health and safety of ISAW with the integrative, coordinative and collaborative efforts in several areas of service delivery. The key recommendations of this study include improvements in healthcare and police response, competencies, policy and practice, education and training and systemic social change led by the government. Recommendations include social change to impact service delivery, policy and practice, encompassing the change in healthcare and police perceptions and attitudes, early identification, risk assessment, safety planning, and coordination and collaboration across services. These recommendations include:

**Healthcare practice and police response**

Improvements by healthcare and police responders at the systems, policy and practice levels, require early identification, thorough an understanding of IPV and cultural risk assessment and safety planning. The development and implementation of culturally appropriate, trauma informed policies and practices will have to be supported by an integrated and intersectional systemic service delivery approach to attain a coordinated and collaborative effort with a strong provincial governmental backing and focus. A comprehensive response strategy will improve the health and safety of ISAW, thereby decreasing IPV related injuries, mental health concerns, visits to emergency and overall lethality to the lives of ISAW and their children.

**Increasing cultural competencies**

Improving service coordination and collaboration, along with a clear understanding of the needs of ISAW, is critical. Achieving enhanced competencies encompasses adopting a culture of safety. Creating a culture of safety implies increasing cultural competencies concerning ISAW, understanding the professional cultural biases that affect their attitudes and perceptions in service delivery efforts and conducting from an IPV trauma informed response. The gains to be made in this area of cultural safety in service delivery are highly unrealised and has the potential to improve and enhance competencies which, in turn, impacts practice for the net gain of saving lives of women, their children and families.

These competencies can be complemented with the understanding offered by the Culturally and Linguistically Trauma Informed Approach (CALTIA), and the risk assessment, employing the Immigrant South Asian Women Risk Assessment Tool (ISAWRAT) proposed in this study, which strives to create an understanding of IPV and risk to safety. The future translation of the ISAWRAT as an online/mobile tool to overcome social isolation and servitude by ISAW can potentially increase accessibility. Digital accessibility to IPV identification, risks and safety planning could assist ISAW, their informal supports and families, with an understanding of IPV, its signs and access to services and resources in this era of virtual supports. This is an area for future focus to increase and improve competencies.

**Policy and practice**

Policy development, its translation into consistent practice, implementation and application, monitoring and evaluation remain a distinct area for greater focus by healthcare and police services. The importance of policies and practices are significant in increasing and improving the coordinated and collaborative work of community based services, healthcare and police responders.

Recognising that these responders form the first point of contact for women and are, thus, key to bridging the gaps between help-seeking, disclosure and service responses, is fundamental to consistent policy and practice. Most importantly, for many women, their children and families, a coordinated and collaborative effort guided by comprehensive and relevant policies and practices could be their only support between life and death. Improving and strengthening the service delivery approach by ensuring culturally and trauma informed policies and practices can be effective in increasing coordination and collaboration in a service delivery approach.

**Education and training**

Education and training of healthcare and police responders is key to ensuring consistent understanding, identification, comfort in asking, clear communication and empathetic response, timely and appropriate referrals, to community social services such as community victim assistance programs for risk assessment and safety planning for ISAW. Therefore, it is essential that healthcare and police curricula provide adequate culturally and trauma informed education and training to strengthen responders' ability to identify, communicate and have knowledge of community resources. It will be crucial to acknowledge and address the healthcare and police professional culture biases. Clear directions and measures for assessing and evaluating the effectiveness and success of such education and training opportunities for responders is essential for impacting change in practice and response.

**Government support and resources**

In order to support a framework of integrated, coordinated and collaborative approach to IPV, it is imperative for all levels of government and community leaders to recognise that improving the health and safety of ISAW is an essential and, a fundamental human right, for all women. This study indicates that any effort will have to be reinforced and endorsed by the political will of government. A dedication and commitment

to sufficiently fund and sustain services and resources, such as crisis lines, community victim assistance programs, transition houses, healthcare and police response, remains essential to serving woman and children experiencing IPV in BC. This study calls for government leadership to go beyond the piecemeal project-based funding for such comprehensive efforts to bear significant results in the effort to eliminate IPV in BC.

### 8.3.1. Culturally and Linguistically Trauma informed Approach (CALTIA) and Immigrant South Asian Women Risk Assessment Tool (ISAWRAT)

The proposed ISAW CALTIA and the ISAWRAT IPV and risk identification is a comprehensive strategy to address and respond to IPV experienced by ISAW. It is based and supported by a framework of responses that is inclusive of key elements and approaches of both the healthcare and police systems. Such a framework of service delivery to IPV of ISAW requires the support of the healthcare and police sectors to ensure:

1. All future development and implementation of resources and services have the foundational understanding of the gaps in services and the challenges facing ISAW to ensure the health and safety of ISAW
2. Development of a comprehensive training module that includes the health and safety of ISAW
3. Development and implementation of guidelines and procedures that assist ISAW at all levels of response within the healthcare and police response systems
4. Ensuring that national and provincial policies and legislation reflect the needs of ISAW
5. Developing collaborative and intersectoral policies and guidelines of practice
6. Ensuring that multi-services of support are sufficiently funded and have long-term budget supports in place
7. Promoting the community and systems level coordinated and holistic responses
8. Increasing and strengthening community-based services
9. Ensuring the ongoing inclusion and engagement of ISAW in addressing challenges and responses
10. Developing and enhancing the capacity of healthcare, police systems, community services and ISAW groups
11. Encouraging and supporting research of IPV and ISAW
12. Monitoring, evaluating and increasing accountability of service and responses to IPV within ISAW communities
13. CALTIA is adapted for other visible and marginalised communities experiencing IPV, both locally and provincially.

## 8.4. Implications of the study

The findings of this study have implications for service delivery, policy, practices, the collaboration and coordination within healthcare and police services, education and training and future research.

Policies and practices based on culturally relevant and trauma informed approaches must be designed for ISAW and applied consistently by well-trained and resourced healthcare and police services, as these are critical. An integrated and intersectoral systemic approach by government, community social services, and healthcare and police services, would support the timely and appropriate service delivery for vulnerable and marginalised immigrant women. Hence, the recommendations made by the participants of the study provide systemic as well as appropriate service response to ISAW for an improved healthcare and police service provision approach.

The utilisation of the ISAW CALTIA framework and the ISAWRAT can enhance and complement existing service delivery policies and practices for both the healthcare and police services. A deeper understanding of the factors outlined in the ISAW CALTIA can inform healthcare and police responders to be both culturally and IPV trauma informed when assisting ISAW in BC.

There are several factors that influence the education, training and skill enhancement for healthcare and police responders in situations of IPV. Training and education opportunities provided at university and repeated at the beginning of their careers, can positively impact professionals' understanding and responses to IPV among ISAW. Sufficient time must be dedicated to understanding the issues and barriers confronting ISAW in IPV situations when preparing healthcare and police practitioners for their careers, ensuring that they are competent and equipped with the knowledge and skills, and an awareness of resources and services within their communities, to support women and prevent lethal outcomes of IPV to the lives of women and children. In addition, ongoing professional development to refresh and enhance cultural and linguistically IPV and trauma informed awareness improves the safety for ISAW.

It is also crucial to have services that are sufficiently resourced and funded to meet the needs of ISAW in IPV situations and remains a subject for future research to determine levels of resources to ensure that needs are met. Future research also needs to focus on clinical and practical applicability, culturally appropriate training and interventions for ISAW and, thereafter, an evaluation of the impact of such training and interventions.

Further evaluation of the RAT among women from other cultural groups will enhance its utility for both women and service providers.

Developing and testing digital self-assessment tools and resource guides is also an area for future research.

## 8.5. Limitations

A number of limitations are recognised within this study. The study focused only on one population: the immigrant South Asian women population (ISAW). The experiences of other immigrant women need to be examined. The study excluded senior women and women with disabilities. These women have other factors that might influence their experiences and they need to be investigated. The study also focused only on women who had accessed health care and police services through the community social services

organisations. Hence, the study did not include women who were currently in intimate partner violence situations. The safety and risks facing these women were among the reasons for their non-inclusion.

The study is limited to one province of British Columbia and hence, limited to the opinions and experiences faced by South Asian women in one province and cannot be generalised or representative of all populations of immigrant South Asian women in other communities. A larger sample of immigrant South Asian women drawn from multiple provinces would offer a better generalisation of the results and recommendations.

The barriers facing women through the justice system were also not examined in this study. A clearer understanding of the justice system and the implications of its rulings is critical when considering a more comprehensive improvement in the services provided for intimate partner violence survivors.

Another limitation of the study was the length of the research study. This study was conducted over six years of part-time PhD candidacy. Provincial policy and political will influences the resources and funding available for services. A change in political will and priorities in certain areas, or for particular populations, influences decision making and support for policies. In British Columbia across the duration of the study, we saw the establishment and the dismantling of the Provincial Office of Domestic Violence (PODV) between 2012 and 2018 (West Coast Leaf, 2018). PODV was established to improve and strengthen a collaborative and coordinated systemic approach to domestic violence in BC.

The ethnic identity of women is excluded from available healthcare and police statistics. As a result, it is often difficult to confirm the exact number of ISAW who reported to police or disclosed to healthcare and community social services. Therefore, it is arduous to approximate the number of ISAW who sought services, were experiencing IPV and had safety concerns. This limits the total population that could be accessed for research purposes.

Identifying sexual violence as part of the IPV experience was not included or explicitly discussed in the study but it requires further focus. Sexual violence among IPV cases poses a higher risk factor for lethality. It was excluded from the study because many South Asian women do not recognise sexual violence within the continuum of IPV and find it difficult to disclose or discuss it.

## 8.6. Suggestions for further research

Based on the study findings, future research can be designed to include a more complex analysis and exploration and extrapolation for robust results. A larger sample size of participants who did not seek formal help from police and healthcare systems can further enhance understanding of challenges facing ISAW. This study focused on ISAW and, thus, a larger sample of immigrant women from different communities can provide a deeper understanding of the gaps facing immigrant women based on the heterogeneity factors among them and their IPV experiences. This study was limited to the geographical location of BC, so a more extensive study of ISAW in different parts of the world could further inform and enrich the health and safety of ISAW. It is important to conduct a study of the professional training available for healthcare

and, in particular nurses, to better recognise the signs of IPV to increase collaboration and seamless service delivery.

Future research should include the community social services organisations and the justice system, as these are other sources of support for women leaving IPV situations. The application and validity of the ISAWRAT and the ISAW CALTIA service delivery construct would further benefit from future research, including the application of online tools to assist with risk assessment and safety planning. Research that encompasses the abuse of online and social media, an evaluation of cultural and trauma informed policies and practices and, education for healthcare professionals during their early career and thereafter, remains unacknowledged. Understanding of the frequency, types and severity of abuse, injuries, mental health implications and fatalities of ISAW in all IPV related situations, not limited to spouses but inclusive of multiple perpetrators of relatives and in-laws, remains an area for further research.

## 8.7. Conclusion

The study is extensive and unique in its data collection which included multiple perspectives: the ISAW survivors who had sought help and had safely left abusive relationships and were from different cities of BC; key informants who were experts with several years of experience in IPV supports in management, service delivery, policy development and implementation from numerous sectors of healthcare, police, community social services and policy analysts as well as frontline responders from across the province of BC, representing both the urban and rural realities of ISAW and service delivery.

As a result the study, it provides significant knowledge for potential improvements to service delivery and policy developments for the reduction of health and safety risks to IPV survivors. An understanding of the multiple and complex factors that delay help-seeking and protection in conjunction with vulnerabilities confronting ISAW, due to the compound layered effects of the response of healthcare and police services, is instrumental in guiding improvements. The projected increase in migration of ISAW to Canada highlights the imperative need to ensure the early identification, risk assessment and greater accessibility, encompassing timely and appropriate healthcare and police services. This will aid the prevention and reduction in injuries, other healthcare concerns and the risk of death to the women, their children and their natal families.

The study highlights the crucial need for provincial and local healthcare and police efforts to be intersectionally coordinated and collaborative, while employing culturally and linguistically, IPV trauma informed practices. These findings provide contributions to improve the health and safety of ISAW by supporting enhanced education of the impacts of IPV, clear communication, development and implementation of policies augmented by consistent application of practices that are both culturally sensitive and competent to ensure equal access, timely and appropriate identification, diagnosis and assessment of risks.

The first contact with responders, including nurses, family physicians and police, remain critical to improvements in service delivery. Positive and supportive attitudes, competence and person-centred communication by healthcare and police professionals, play an important role in increasing help- seeking and disclosure by ISAW in highly vulnerable and risky IPV related situations.

**Table 8.1: Plan for Dissemination of Findings and Translation to Practice**

The recommendations for policy and practice from the study will be disseminated as follows:

| **Dissemination of research results** | |
|---|---|
| Thesis submitted for examination by the PhD candidate | Publications in peer reviewed academic journals |
| **Conferences:**<br><br>1. Annual Training Forum, BC Society of Transition Houses, October 19-23, 2020 Vancouver, Canada | **Qualitative papers Interview Results:**<br><br>1. Diversity & Equality in Health and Care Journal<br><br>2. Journal of Community & Public Health Nursing<br><br>3. Journal of Women's Health, Issues and Care<br><br>4. Qualitative Health Research Journal |
| Final written reports to the community partners and face-to-face presentation to staff at:<br><br>1. BC Society Transition Houses www.bcsth.ca<br>2. Community Programs, Community Safety & Crime Prevention Branch, Ministry of Public Safety and Solicitor General www.gov.bc.ca/pssg | The PhD candidate plans to pursue research and community funding for testing of ISAWRAT, digital resources and translation of study outcomes to policy and practice |

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# Appendix A. Permission Letter and Consent Forms

BC Society of Transition Houses

Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model.

29 September 2015

Professor Wendy Cross
Head, School of Nursing and Midwifery
Monash University, Faculty of Medicine, Nursing and Health Sciences
Building 13C, Room 179b Clayton Campus
Wellington Road, Clayton, Victoria 3800
Telephone: +61 3 9905 4839 / Fax: +61 3 9905 4837
wendy.cross@monash.edu

**Dear Wendy**,

**Thank you for your request to recruit and conduct a focus group for service providers at the British Columbia Society of Transition Houses for the above-named research.**

**I have read and understood the Explanatory Statement regarding the research project**: Creating Safety: Intersection of Healthcare and Police Response to Violence against Immigrant South Asian Women in British Columbia: A Service Provision Model, **and hereby give permission for this focus group to be conducted at our organization.**

**Yours sincerely.**

Joanne Baker

Dr Joanne Baker
Training & Programs Manager

Suite 325, 119 W. Pender St. Vancouver, BC V6B 1S5
T: 604.669.6943 | TF: 1.800.661.1040 | F: 604.682.6962 | **www.BCSTH.ca**

MONASH University

## CONSENT FORM

**(Relevant Participant Group)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model.**

**Chief Investigator: Professor Wendy Cross**
**Head, School of Nursing and Midwifery**
**Monash University, Faculty of Medicine, Nursing and Health Sciences**
**Building 13C, Room 179b Clayton Campus**
**Wellington Road, Clayton, Victoria 3800**
**Telephone: +61 3 9905 4839 / Fax: +61 3 9905 4837**
**wendy.cross@monash.edu**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

| I consent to the following: | Yes | No |
|---|---|---|
| | | |
| Taking part in a Key Informant Interview | ☐ | ☐ |
| Audio recording during the interview | ☐ | ☐ |

Name of Participant _____

Participant Signature _____ Date _____

MONASH University

## CONSENT FORM

**(Relevant Participant Group)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model.**

**Chief Investigator: Professor Wendy Cross**
**Head, School of Nursing and Midwifery**
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**Telephone: +61 3 9905 4839 / Fax: +61 3 9905 4837**
**wendy.cross@monash.edu**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

| I consent to the following: | Yes | No |
|---|---|---|
| | | |
| Taking part in a focus group of up to 10 service providers/experts | ☐ | ☐ |
| Audio recording during the focus group | ☐ | ☐ |

Name of Participant _____

Participant Signature _____ Date _____

MONASH University

## CONSENT FORM

**(Relevant Participant Group)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model.**

**Chief Investigator: Professor Wendy Cross**
**Head, School of Nursing and Midwifery**
**Monash University, Faculty of Medicine, Nursing and Health Sciences**
**Building 13C, Room 179b Clayton Campus**
**Wellington Road, Clayton, Victoria 3800**
**Telephone: +61 3 9905 4839 / Fax: +61 3 9905 4837**
**wendy.cross@monash.edu**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

| I consent to the following: | Yes | No |
|---|---|---|
| | | |
| Taking part in a focus group of up to 10 women | ☐ | ☐ |
| Audio recording during the focus group | ☐ | ☐ |
| Maintain the confidentiality of information shared in the focus group<br>I understand that information related to abuse of children cannot be kept confidential as anyone who has reason to believe that a child has been or is likely to be abused or neglected has a legal duty under the Child, Family and Community Service Act to report the matter. | ☐ | ☐ |

Name of Participant _____

Participant Signature _____ Date _____

## Appendix B. Explanatory Statements

MONASH University

**EXPLANATORY STATEMENT**

**(Key Informant Interview)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model. (CF15/4343 – 2015001875)**


**Prof Wendy Cross**
Department of Nursing & Midwifery
Phone: +61 3 9905 4839
email: wendy.cross@monash.edu

**Harjit Kaur, Phd Student,**
Phone : 604 613 6583 or
+61 0404432614
email: hkau7@student.monash.edu


You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

**What does the research involve?**

The research project will examine the intersection of healthcare and policing responses to domestic violence against immigrant South Asian women of British Columbia (BC), and will provide an understanding for the creation of safety measures both in services and policies as part of a range of possible solutions to address this issue. In order to ensure that the healthcare and safety nets do not fail immigrant South Asian women experiencing violence in relationships, it is important that an effective response system is established. As a key informant, you are in a position to share your knowledge and experience to inform the project findings and recommendations for improved services and policies.

There continue to be gaps in service provision that can be improved to increase the safety of immigrant South Asian women. The existing gaps are evident from the low reporting rates, continuing injuries and homicides related to domestic violence, insufficient resources dedicated to screening, education and support for self- disclosures within healthcare settings. These gaps could potentially further endanger the life of the woman and her children without the appropriate risk management and safety planning supports.

As part of this study, individual interviews with at least six key informants and service providers working with immigrant South Asian women in healthcare and policing will be done in-person or on the phone/skype based on your availability. Representatives from the healthcare, justice, anti-violence and policing sectors will be invited to participate in the interviews. The interview will last for approximately thirty minutes to an

hour. We have a series of questions to ask. Some of the most valuable information and insight can come from these kinds of conversations.

The interviews will be used to identify gaps in current policies and services. The findings will provide information relating to barriers and challenges resulting from system and service policies. It will be important to understand the concept of creating safety in the prevention and intervention of violence against women, the importance of risk assessment/management and safety planning training, and increased coordination and collaboration between service providers and policymakers. We hope the findings and recommendations for service and policy options will provide an understanding within the context of the South Asian community and the existing provincial framework.

In addition to these interviews, focus groups are being held in 4 communities across BC: Vancouver, Fraser Valley, Prince George and Kelowna to gather information about what is working and what is not working and what can be improved in services for immigrant South Asian women who have experienced domestic violence – from the point of view of survivors themselves. An online survey is also being conducted of frontline service providers to gather critical information to inform the findings of the research study.

**Why were you chosen for this research?**

We chose you as subject matter experts and policymakers working with domestic violence for this project because we want to understand the gaps/barriers from your point of view. We liaised with Community-based Victim Assistance/Settlement programs and the organizations you work with to obtain your contact details. Your contact details will remain confidential with us.

**Consenting to participate in the project and withdrawing from the research**

Please note that:

- You participate in the research on own free will. Your written consent is required. You will be required to sign and return one copy of the consent form prior to the interview. The other copy will be for your reference.
- Your participation is voluntary and that there are no consequences for refusing to take part in the interview.
- You may stop the interview at any time and decline to answer specific questions without any implications of withdrawal.

**Possible benefits and risks to participants**

Participants will be contributing to improving the gaps in services faced by immigrant South Asian women interacting with the healthcare and police systems. Research studies such as this one will inform the work of systems and policymakers to take all steps to improve the safety of women and their children experiencing domestic violence.

It is important that you understand the benefits and potential risk of the interview so that you can give your genuine informed consent to take part.

We do not anticipate any personal risk involved in you participating in this interview. In case you experience or are aware of any risk to you or your organization, please feel free to withdraw from the interview or decline answering any question of such nature. There is no intended risk to your participation in the interview.

**Services on offer if adversely affected**

In case you experience the need to seek support for feelings that come up after you end the session or over the next couple of days, please call:

- Victim Link BC, toll free 24/7 at 1-800-563-0808.

**Payment**

- There is no payment for participation in the research

**Confidentiality**

- The facilitator will keep personal information that is revealed to them confidential.
- The facilitator will audio tape and take notes during the interview but will not share any information or identify any direct quote made by you to preserve your confidentiality that would otherwise allow another person to identify what you said in the study, unless you provide permission to do so.
- Others working on the study, doing the transcription, will have access to the tapes, notes from the interview, and the names of who said what. Your name and that of your organization will be used to acknowledge your contribution in the study.
- We encourage participants to only respond with information that they are comfortable with sharing.

**Storage of data**

The data collected as part of the research study will be stored to ensure that:

- De-identified data will only be available to the researcher and other authorized users: supervisors and data transcribers
- Only hard copies of the data will be stored in a locked filing cabinet at Monash University, Clayton campus, accessible only by the researcher
- Standard security and access controls will be put in place to prevent loss, theft or unauthorized use
- Automated systems will be in place as backup
- The research data is usually kept for 5 years from the completion of the project or the time that the results of the research are published (whichever is later).

**Use of data for other purposes**

The de-identified data will not be used by any other project.

**Results**

The results of the study will be made available upon the completion of the research thesis and participants will be able to access the findings when a copy is made available to your organization.

**Complaints**

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact in British Columbia:

Joanne Baker PhD

Executive Director

BC Society of Transition Houses

Suite 32, 119 W. Pender St. Vancouver BC V6B 1S5

Tel: 604 669 6943 ext. 233 Email: joanne@bcsth.ca Fax: 604 682 6962

Or

Executive Officer, Monash University Human Research Ethics (MUHREC):

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Thank you,

**Prof Wendy Cross**

Department of Nursing & Midwifery

MONASH University

**EXPLANATORY STATEMENT**

**(Online Survey Participants)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model (CF15/4343 – 2015001875)**


**Prof Wendy Cross, RN PhD FACN FACMHN**
Department of Nursing & Midwifery
Phone: +61 3 9905 4839
email: wendy.cross@monash.edu

**Harjit Kaur, Ph.D Student,**
Phone : 604 613 6583
email: hkau7@student.monash.edu


You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

**What does the research involve?**

The research project will examine the intersection of healthcare and policing responses to domestic violence against immigrant South Asian women of British Columbia (BC), and will provide an understanding for the creation of safety measures both in services and policies as part of a range of possible solutions to address this issue. In order to ensure that the healthcare and safety nets do not fail immigrant South Asian women experiencing violence in relationships, it is important that an effective response system is established. As a participant of the online survey, you are in a position to share your knowledge and expertise to inform the project findings and recommendations for improved services and policies.

There continue to be gaps in service provision that can be improved to increase the safety of immigrant South Asian women. The existing gaps are evident from the low reporting rates, continuing injuries and homicides related to domestic violence, insufficient resources dedicated to screening, education and support for self- disclosures within healthcare settings. Presently, help-seeking by an immigrant South Asian woman could result in a self-disclosure to a healthcare practitioner or a call to the police. Knowledge of when, where and how to make appropriate and time sensitive referrals, the social and economic location of the woman and her children, guided by clear and concise practice policies and protocols are often cited as some of the critical components of safety for her and her children.

As part of this study, frontline service providers from organizations including crisis response and specialized anti-violence programs, settlement programs, transition and safe houses around the province of British Columbia, are invited to participate in an online survey. The online survey will be forwarded to you, as

frontline workers through your respective organizations across the province. You are invited to discuss the issues of concerns confronting your immigrant South Asian clients who have experienced domestic violence. You are invited to discuss the nature of problems, barriers and risk factors facing your clients when accessing healthcare and police services. You are invited to complete the anonymous online survey. Your experience and knowledge of working with survivors of domestic violence as they interact with systems and the challenges they face will be valuable in informing the findings of this study.

**Why were you chosen for this research?**

We chose to conduct this online survey of frontline workers working directly or indirectly with immigrant South Asian women survivors of domestic violence as participants for this project because we want to understand the gaps/barriers from your point of view and experience. We also hope to gain valuable understanding of your service and policy suggestions of what can be done to enhance and improve the experience of survivors seeking healthcare and police protection services. This online survey is anonymous and hence your participation will remain confidential.

**Consenting to participate in the project and withdrawing from the research**

Please note that:

- You participate in the research on your own free will. The online survey is anonymous and your consent is implied should you choose to complete and submit the online survey.
- Your participation is voluntary and that there are no consequences for refusing to take part in the online survey.
- You may choose withdraw your participation or not submit the survey at any time and decline to answer specific questions without any implications of withdrawal.

**Possible benefits and risks to participants**

Participants will be contributing to improving the gaps in services and policies faced by immigrant South Asian women interacting with the healthcare and police systems. Research studies such as this one will inform the work of systems and policymakers to take all steps to improve the safety of women and children experiencing domestic violence.

It is important that you understand the benefits and any potential risk of completing the online survey so that your genuine informed consent to take part is indicated by submitting the online survey.

We do not anticipate any risk involved in you participating in this anonymous and voluntary online survey. In case you experience or are aware of any risk to you or your organization, please feel free to withdraw from the online survey or omit answering any question of such nature. There is no intended risk to your participation in the online survey.

**Services on offer if adversely affected**

In case you experience the need to seek support for feelings that come up after you complete the online survey or over the next couple of days, please call:

- Victim Link BC, toll free 24/7 at 1-800-563-0808

**Payment**

- There is no payment for participation in the research

**Confidentiality**

- The online survey is anonymous and your consent is implied should you choose to complete and submit the online survey.
- Your participation is voluntary and that there are no consequences for refusing to take part in the online survey.
- You may choose withdraw your participation or not submit the survey at any time and decline to answer specific questions without any implications of withdrawal.
- The researcher will analyse the data from the online survey and the results will only be used to derive recommendations and possible solutions to enhance and improve the safety of immigrant South Asian women and their children.
- Although the online survey is anonymous, we encourage participants to only respond with information that they are comfortable with sharing.

**Storage of data**

- The data collected as part of the research study will be stored to ensure that:
- De-identified data will only be available to the researcher and other authorized users: supervisors and data transcribers
- Only hard copies of the data will be stored in a locked filing cabinet at Monash University, Clayton campus, accessible only by the researcher
- Standard security and access controls will be put in place to prevent loss, theft or unauthorized use
- Automated systems will be in place as backup
- The research data is usually kept for 5 years from the completion of the project or the time that the results of the research are published (whichever is later).

**Use of data for other purposes**

The de-identified data will not be used by any other project.

**Results**

The results of the study will be made available upon the completion of the research thesis and all community members will be able to access the findings made available at community organizations.

**Complaints**

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact in British Columbia:

Joanne Baker PhD

Executive Director

BC Society of Transition Houses

Suite 32, 119 W. Pender St. Vancouver BC V6B 1S5

Tel: 604 669 6943 ext. 233 Email: joanne@bcsth.ca Fax: 604 682 6962

Or

Executive Officer, Monash University Human Research Ethics (MUHREC):

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e, Research Office

Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Thank you,

**Prof Wendy Cross**

Department of Nursing & Midwifery

MONASH University

**EXPLANATORY STATEMENT**

**(Service Providers Focus Group)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model (CF15/4343 – 2015001875)**


**Prof Wendy Cross**
Department of Nursing & Midwifery
Phone: +61 3 9905 4839
email: wendy.cross@monash.edu

**Harjit Kaur, Phd Candidate,**
Phone : 604 613 6583 or
+61 0404432614
email: hkau7@student.monash.edu


You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

**What does the research involve?**

The research project will examine the intersection of healthcare and policing responses to domestic violence against immigrant South Asian women of British Columbia (BC), and will provide an understanding for the creation of safety measures both in services and policies as part of a range of possible solutions to address this issue. In order to ensure that the healthcare and safety nets do not fail immigrant South Asian women experiencing violence in relationships, it is important that an effective response system is established. As a participant of the focus group, you are in a position to share your experiences to inform the project findings and recommendations for improved services and policies.

There continue to be gaps in service provision that can be improved to increase the safety of immigrant South Asian women. The existing gaps are evident from the low reporting rates, continuing injuries and homicides related to domestic violence, insufficient resources dedicated to screening, education and support for self- disclosures within healthcare settings. At present, help-seeking by an immigrant South Asian woman could result in a self-disclosure to a healthcare practitioner or a call to the police. This action could potentially further endanger the life of the woman and her children without the appropriate risk management, appropriate policies, protocols and safety planning supports.

As part of this study, focus groups are being held in 4 communities across BC: Vancouver, Fraser Valley, Prince George and Kelowna to gather information about what is working and what is not working and what can be improved in services for immigrant South Asian women who have experienced domestic violence – from the point of view of survivors themselves.

The session will last for about an hour – no longer than an hour and a half. We have a series of questions to ask. They are about your experience and knowledge of women seeking support so there can be no wrong answers. Focus groups are about discussion and dialogue so you have the opportunity to share your expertise with and respond to each other. Some of the most valuable information and insight can come from these kinds of conversations.

**Why were you chosen for this research?**

We chose service providers, policy makers and senior management as participants for this project because we want to understand the gaps/barriers/challenges from you and your organization's point of view and experience. We liaised with Community-based Victim Assistance/Settlement programs and the organizations you work with to obtain your contact details. Your contact details will remain confidential.

**Consenting to participate in the project and withdrawing from the research**

Please note that:

- You participate in the research on own free will and with permission from your organization. Your written consent is required. You will be required to sign and return one copy of the consent form. The other copy will be for your reference.
- Your participation is voluntary and that there are no consequences for refusing to take part in the focus group.
- You may leave the focus group at any time and decline to answer specific questions without any implications of withdrawal.

**Possible benefits and risks to participants**

Participants will be contributing to improving the gaps in services faced by immigrant South Asian women interacting with the healthcare and police systems. Research studies such as this one will inform the work of systems and policymakers to improve the safety of women and children experiencing domestic violence.

It is important that you understand the benefits and potential risk of the focus group so that you can give your genuine informed consent to take part.

Talking about your experience or hearing about your colleagues sharing their experiences and knowledge relating to the gaps, barriers and challenges faced by women and children could bring up feelings of discomfort or unease. Please feel free to leave the room at any time to take care of yourself or approach the facilitator after the session.

**Payment**

- There is no payment for participation in the research.

**Confidentiality**

- The facilitator and audio tape/note-taker will keep personal information that is revealed to them confidential. The facilitator will not share any information or identify any direct quote made by

you to preserve your confidentiality that would otherwise allow another person to identify what you said in the study, unless you provide permission to do so.

- The names of the participants and their organizations will be acknowledged in the study.
- Others working on the study, doing the transcription, will only have access to the tapes and notes from the focus group discussions.
- In a focus group setting, the facilitator cannot guarantee that other members will not break confidentiality, even though they will be asked to agree to this. We will encourage participants to only respond with information that they are comfortable with sharing about their work and organization.

**Storage of data**

The data collected as part of the research study will be stored to ensure that:

- De-identified data will only be available to the researcher and other authorized users: supervisors and data transcribers
- Only hard copies of the data will be stored in a locked filing cabinet at Monash University, Clayton campus, accessible only by the researcher
- Standard security and access controls will be put in place to prevent loss, theft or unauthorized use
- Automated systems will be in place as backup
- The research data is usually kept for 5 years from the completion of the project or the time that the results of the research are published (whichever is later).

**Use of data for other purposes**

The de-identified data will not be used by any other project.

**Results**

The results of the study will be made available upon the completion of the research thesis and participants will be able to access the findings when a copy is made available to their organization.

**Complaints**

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact in British Columbia:

Joanne Baker PhD

Executive Director

BC Society of Transition Houses

Suite 32, 119 W. Pender St. Vancouver BC V6B 1S5

Tel: 604 669 6943 ext. 233 Email: joanne@bcsth.ca Fax: 604 682 6962

Or

Executive Officer, Monash University Human Research Ethics (MUHREC):

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

Monash University VIC 3800

Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Thank you,

**Prof Wendy Cross**

Department of Nursing & Midwifery

MONASH University

**EXPLANATORY STATEMENT**

**(Focus Group Participants)**

**Project: Creating Safety: Intersection Of Healthcare And Police Response To Domestic Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model (CF15/4343 – 2015001875)**


**Prof Wendy Cross**
Department of Nursing & Midwifery
Phone: +61 3 9905 4839
email: wendy.cross@monash.edu

**Harjit Kaur, Phd Candidate,**
Department of Nursing & Midwifery
Phone: 604 613 6583
email: hkau7@student.monash.edu


You are invited to take part in this study. Please read this Explanatory Statement in full before deciding to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

**What does the research involve?**

The research project will examine the intersection of healthcare and policing responses to domestic violence against immigrant South Asian women of British Columbia (BC). It will provide an understanding for the creation of safety measures both in services and policies as part of a range of possible solutions to address this issue. In order to ensure that the healthcare and safety nets do not fail immigrant South Asian women experiencing violence in relationships, it is important that an effective response system is established. As a participant of the focus group, you are in a position to share your experiences to inform the project findings and recommendations for improved services and policies.

Gaps in service provision can be improved to increase the safety of immigrant South Asian women. The existing gaps are evident from the low reporting rates, and continuing injuries related to domestic violence, insufficient resources dedicated to screening, education and support for self- disclosures within healthcare settings. At present, help-seeking by an immigrant South Asian woman could result in a self-disclosure to a healthcare practitioner or a call to the police. This action could potentially further endanger the life of the woman and her children without the appropriate risk management and safety planning supports.

As part of this study, focus groups are being held in 4 communities across BC: Vancouver, Fraser Valley, Prince George and Kelowna to gather information about what is working, what is not working and what can be improved in services for immigrant South Asian women who have experienced domestic violence – from the point of view of survivors themselves.

The session will last for approximately an hour – no longer than an hour and a half. We have a series of questions to ask. They are about your own experience of seeking support so there can be no wrong

answers. Focus groups are about discussion so you have the opportunity to talk with and respond to each other. Some of the most valuable information and insight can come from these kinds of conversations.

**Why were you chosen for this research?**

We chose survivors of domestic violence as participants for this project because we want to understand the gaps/barriers/challenges from your point of view. We liaised with Community-based Victim Assistance/Settlement programs and the community organizations to invite you to participate. Your contact details will remain confidential with us.

**Consenting to participate in the project and withdrawing from the research**

Please note that:

- You participate in the research on your own free will. Your written consent is required. You will be required to sign and return one copy of the consent form. The other copy will be for your reference. Please be careful with what you do with your copy of the Consent Form and other material from the Project, as if others find that you are involved with the project it may increase the risk of domestic violence.
- Your participation is voluntary and there are no consequences for refusing to take part in the focus group (such as any change to the service you currently or in the future receive from a service organization).
- You may leave the focus group at any time and decline to answer specific questions without any implications of withdrawal.

**Possible benefits and risks to participants**

Participants will be contributing to improving the gaps in services faced by immigrant South Asian women interacting with the healthcare and police systems. Research studies such as this one will inform the work of systems and policymakers to take all steps to improve the safety of women and children experiencing domestic violence.

It is important that you understand the benefits and potential risk of the focus group so that you can give your genuine informed consent to take part in it. It is important to note that all information relating to your knowledge and/or participation in the focus group could increase your risk from your partner or ex-partner. We suggests that you take caution in bringing home any related information i.e. the flyer, this Project Explanatory Statement or the consent form. We suggest that any information relating to this project or your participation be kept in a safe place or not removed from the focus group venue. Please feel free to discuss any concerns with the facilitator of the focus group.

Talking about your experience or hearing about other participants experiences could bring up feelings of discomfort or unease. Please feel free to leave the room at any time to take care of yourself, approach the crisis support person in the room or approach the facilitator or crisis support person after the session.

**Services on offer if adversely affected**

In case you experience the need to seek support for feelings that come up after you leave the session or over the next couple of days, please call:

- Victim Link BC, toll free 24/7 at 1-800-563-0808

**Payment**

- Participants will be offered reimbursements for mileage @ 44 cents per km/or transit fare
- A $20 gift voucher will be offered as a thank you for participation.

**Confidentiality**

- The facilitator and audio tape/note-taker will keep personal information confidential and will not share any information that would allow another person to know who participated in the study.
- Others working on the study will only have access to the de-identified data. Pseudonyms rather than real names will be used. No information will be reported that would identify you as a participant in the study, unless you do not prior approval.
- In a focus group, the facilitator cannot guarantee that other participants will not break confidentiality, even though they will be asked to agree to this. Participants are encouraged to only share information that they are comfortable with sharing. There is a possibility that a participant(s) is known to you. We request that you maintain the confidentiality of your fellow participants in such a situation.
- Exception to confidentiality: Anyone who has reason to believe that a child has been or is likely to be abused or neglected has a legal duty under the *Child, Family and Community Service Act* to report the matter.

**Storage of data**

The data collected as part of the research study will be stored to ensure that:

- It will only be available to authorized users: supervisors and data transcribers
- Only hard copies of the data will be stored in a locked filing cabinet at Monash University, Clayton campus, accessible only by the researcher
- Standard security and access controls will be put in place to prevent loss, theft or unauthorized use
- Automated systems will be in place as backup
- The research data is usually kept for 5 years from the completion of the project or the time that the results of the research are published (whichever is later).

**Use of data for other purposes**

The de-identified data will not be used by any other project.

**Results**

The results of the study will be made available upon the completion of the research thesis and participants will be able to access the findings when a copy is made available to the community organization.

**Complaints**

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact in British Columbia:

Joanne Baker PhD

Director of Training& Programs

BC Society of Transition Houses

Suite 32, 119 W. Pender St. Vancouver BC V6B 1S5

Tel: 604 669 6943 ext. 233 Email: joanne@bcsth.ca Fax: 604 682 6962

Or

Executive Officer, Monash University Human Research Ethics (MUHREC):

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

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Tel: +61 3 9905 2052 Email: muhrec@monash.edu Fax: +61 3 9905 3831

Thank you,

**Prof Wendy Cross,** Department of Nursing & Midwifery

## Appendix C. Questions

**Creating Safety Project:**

**Key Informant Interview Questions**

**(Estimated time – 1hour)**

Thank you so much for taking the time to share your most valuable expertise with us. We believe that your experience and knowledge of healthcare/police system will benefit our project and the immigrant South Asian survivors, women from the Indian subcontinent, and have experienced domestic violence.

This interview with service providers/policy makers will be used to identify gaps in current policies and services. The information you provide will help us to identify barriers and challenges resulting from services and government policies. It is important for us to understand the concept of creating safety in the prevention and intervention of violence against women, the importance of risk assessment and safety planning training, and increased coordination and collaboration between service providers.[1] Available policy options will provide an understanding within the context of the South Asian community and the existing provincial framework.

We would like to audio tape this interview to ensure that we do not miss any information. The audio recording will be erased once the notes are done. No views or quotes will be attributed to you in the report without your prior approval.

**Questions:**

1. Describe your role, knowledge, and experience of dealing with the situations of domestic violence experienced by immigrant South Asian women?
2. What are some gaps/barriers preventing them from seeking healthcare or help from the police?
3. What are effective interventions in increasing the safety of women seeking healthcare/police interventions in BC?
4. How do persons threatened with domestic violence deal with their family and social circle, when deciding to seek healthcare/police help?
5. How effective are government responses/policies in BC to this issue?
6. How do healthcare/police/RCMP perceive immigrant South Asian women?
7. What type of assistance do healthcare/police/RCMP offer women who are threatened with or who are victims of domestic violence?

8. What protocols/policies guide service providers within your sector when responding to disclosure/reporting domestic violence?
    a. Can you provide us with a copy or advise us as to where we can obtain more information?
    b. Are these sufficient? If no, what materials/resources/ opportunities do you think would be useful in assessing risk and improving safety?
9. Are there any promising practices/policies that are emerging in your sector in identifying and responding to cases of immigrant South Asian women?
10. What recommendations can you make to improve and enhance the help-seeking by immigrant South Asian women in BC?
11. Is there anything that you think we should have included?
12. Is there anything else you would like to add?

**Thank you so much for your time and participation.**

**If you have any questions, please do not hesitate to contact Harjit Kaur, Researcher, at hkau7@student.monash.edu or call her at 604-613-6583**

**Reference:**


1. Critical Components Project Team. (2008). *Keeping Women Safe: Eight Critical Components of an Effective Justice Response to Domestic Violence.* Vancouver, BC: BC Association of Specialized Victim Assistance and Counselling Programs, and Victoria Women's Transition House Society.
2. Ending Violence Association of BC project template

**Creating Safety: Intersection of Healthcare and Police Response to Violence Against Immigrant South Asian Women in British Columbia: A Service Provision Model**

**Online Survey for Service Providers**

**INTRODUCTION**

Creating Safety for Immigrant South Asian Women Project is part of a PhD research study undertaken by Harjit Kaur, Monash University, Australia, under the supervision of Professor Wendy Cross and Associate Professor Allison Williams. The study focuses on improving responses to domestic violence experienced by immigrant South Asian women in BC by healthcare and police services. It is important that healthcare practitioners and the police services are better informed, more coordinated and have a deeper understanding of the immediate and long-term implications of domestic violence experienced by immigrant South Asian women in BC.

We seek your expertise, knowledge and frontline experience of working with immigrant South Asian women who have experienced domestic violence. We are interested to hear about the needs of immigrant women in your communities, about what is working well for them with healthcare and police responses to domestic violence as well as what is not working well and how these responses and services can be improved for immigrant South Asian women across BC.

Information gathered from this survey will inform us on the challenges faced by immigrant South Asian women when accessing healthcare and police services and how responses by healthcare and policing can be improved to increase the safety of women. Information you share will support future work by:

1. Informing and guiding the development of services and resources in healthcare and police services
2. Providing feedback/direction to policy makers to better serve immigrant, marginalized and isolated South Asian women and communities across BC.

**This survey will take approximately 20 minutes to complete.**

**Please complete survey by 5 p.m. 2016.**

**Part 1: Domestic Violence: Immigrant South Asian Women – Service Needs and Gaps**

**Part 2: Increasing Accessibility/Resources**

i. **Accessing Healthcare**
ii. **Accessing Police Protection**

| *1. What program(s) do you work in? (Please check all that apply) |
|---|
| ☐ Police-based Victim Services |
| ☐ Community-based Victim Services |
| ☐ Stopping the Violence Counselling |
| ☐ Stopping the Violence Outreach |
| ☐ Multicultural Outreach |
| ☐ Settlement program |
| ☐ ELSA program |
| ☐ Transition/Safe House |
| ☐ Healthcare/Medical practitioner: please specify |
| ☐ Police/RCMP officer: please specify |
| ☐ Other: |

**2. Confidentiality:**

Your email address and your organization name will allow us to share with you the study results. You can choose not to share your email address.

Any information provided in the survey will be kept confidential and stored according to the guidelines approved by Monash University Research Ethics Committee.

Please enter the information indicated below.

Organization/Agency Name:

Email Address: emailaddress@xyz.com

**PART 1: DOMESTIC VIOLENCE: IMMIGRANT SOUTH ASIAN – SERVICE NEEDS AND GAPS**

| 3. **Do you believe that immigrant South Asian women experiencing domestic violence face barriers when accessing healthcare services?** |
|---|
| ☐ Yes |
| ☐ No |

| **4. Do you believe that immigrant South Asian women experiencing domestic violence face barriers when accessing police services?** |
|---|
| ☐ Yes |
| ☐ No |

| **5. Have you or your program staff provided assistance to immigrant South Asian women experiencing domestic violence?** |
|---|
| ☐ Yes |
| ☐ No |
| ☐ Do Not Know |

| **6. Have you or your program staff suspected or known of immigrant South Asian women experiencing domestic violence in your community?** |
|---|
| ☐ Yes |
| ☐ No |
| ☐ Do Not Know |

| **7. If "yes", what caused you to think these situations exists in your community? (please check all that apply)** |
|---|
| ☐ Direct Disclosure by woman |
| ☐ Information from another source e.g. information from another individual/family/friend or from documentation relating to access to other services |
| ☐ Indirect disclosure by woman while talking about something else |
| ☐ A general assumption of the community members |
| ☐ Through the school system or educators |
| ☐ Through community partners such as settlement services, police, healthcare, mental health, transition houses |
| ☐ Other service providers |
| ☐ Other, please specify |
| |
| **8. What challenges do immigrant South Asian women disclose when accessing healthcare or police services? (please check all that apply)** |
| ☐ Worry about social and cultural implications for them, their children, parents and relatives |
| ☐ Being a good daughter/wife and keeping the domestic violence a private matter |
| ☐ Maintaining family peace |
| ☐ Produce a son/extend the lineage |
| ☐ Patriarchal structure |
| ☐ Are new to the community/country |
| ☐ Are isolated from family and friends |
| ☐ Not allowed to visit the doctor without a family member |
| ☐ Do not have access to a phone/internet |
| ☐ Lack of knowledge regarding the medical and police systems |
| ☐ Fear of what could happen to them or their children if they report to the police |
| ☐ Fear of being deported or losing their immigration status |
| ☐ Lack of support from the community and family if they choose to report to the police or disclose to health care practitioners |
| ☐ Other: |

| **9. In the last 3 years, how many immigrant South Asian clients have you worked with who were impacted by domestic violence?** |
|---|
| ☐ 0 |
| ☐ 1 - 5 |
| ☐ 6 - 10 |
| ☐ 11 - 15 |
| ☐ 16 - 20 |
| ☐ More than 20; please specify: |
| ☐ Do not know |

| |
|---|
| ☐ Not applicable |

| **10. What was the age of the clients you worked with? (please check all that apply)** |
|---|
| ☐ Under 12 |
| ☐ 12 - 15 |
| ☐ 16 - 19 |
| ☐ 20 - 25 |
| ☐ 26 - 35 |
| ☐ 36 - 45 |
| ☐ 46 - 55 |
| ☐ Over 55 |

| **11. What was their language preference? (please check all that apply)** |
|---|
| ☐ English |
| ☐ Punjabi |
| ☐ Hindi |
| ☐ Fijian |
| ☐ Arabic |
| ☐ Do not know |
| ☐ Other: |

| **12. What do you believe are gaps or barriers for immigrant South Asian women seeking crisis and practical assistance in your community?** |
|---|
| ☐ Inadequate funding for programs providing assistance to women |
| ☐ Lack of clear provincial policies to support immigrant South Asian women |
| ☐ Insufficient culturally appropriate training to community services, police and medical practitioners |
| ☐ Not believing the victim/survivor |
| ☐ Lack of attention to victim safety, language needs |
| ☐ Lack of attention to physical needs |
| ☐ Lack of trauma informed response |
| ☐ Breaching privacy/confidentiality |
| ☐ Lack of transport |
| ☐ Distance from services |
| ☐ Inadequate services (services not available or limited availability) |
| ☐ Lack of referrals/inappropriate referrals |

| **13. What intervention or action is needed to support women impacted by domestic violence to access healthcare services in your community? (please check all that apply)** |
|---|
| ☐ No specific intervention |
| ☐ Provide appropriate information about the services in the community, media, places visited by women |
| ☐ Provide accompaniment to healthcare services |
| ☐ Provide emotional support and practical assistance to navigate the healthcare system |
| ☐ Provide translation and culturally appropriate information |
| ☐ Review risk factors for abuse or violence |

| |
|---|
| ☐ Referral to an appropriate service within your community or elsewhere to provide safety planning |
| ☐ Referral to child protection (where client has children under 19 years of age) |
| ☐ Referral to legal aid/services |
| ☐ Increase collaboration with the healthcare system |
| ☐ Do not know |
| ☐ Other: |

| **14**. **Does your agency/program have specific guidelines, policies or identified good practices which support immigrant South Asian women impacted by domestic violence?** |
|---|
| ☐ Yes, please specify below |
| ☐ No |
| ☐ Do not know |
| ☐ Not applicable |
| ☐ Comment: 500 characters |

| **15**. **What gaps and challenges do you face when working with an immigrant South Asian woman impacted by domestic violence? (please check all that apply)** |
|---|
| ☐ Lack of interpretation services |
| ☐ Lack of appropriate counselling and crisis support services |
| ☐ Lack of workers who speak the language |
| ☐ Lack of knowledge of community services and supports in the community |
| ☐ Do not understand the culture of newcomer clients |
| ☐ Lack of knowledge of risks and safety planning for clients |
| ☐ Difficulty locating legal support |
| ☐ Difficulty accessing medical services |
| ☐ Difficulty getting police assistance |
| ☐ Lack of housing options |
| ☐ Lack of accessibility to settlement services for newcomers to Canada |
| ☐ Inadequate information regarding immigration issues and options to leave abusive relationships |
| ☐ Not applicable |
| ☐ Other: |

| **16**. **What intervention or action is needed to support immigrant South Asian women impacted by domestic violence to access police protection services in your community? (please check all that apply)** |
|---|
| ☐ No specific intervention |
| ☐ Understanding the VAWIR provincial policy and the primary aggressor policy |
| ☐ Understanding the implications of dual arrests where the women is the survivor in the relationship |
| ☐ Sufficient translation/interpretation services independent of family members/spouse doing it |
| ☐ Provide appropriate information about the police services and process in the community, media, places visited by women |
| ☐ Provide accompaniment to seek police protection services |
| ☐ Provide emotional support and practical assistance to navigate the policing system |
| ☐ Review risk factors for abuse or violence |
| ☐ Referral to an appropriate community service to engage in risks management and safety planning |
| ☐ Referral to legal aid/services |

| |
|---|
| ☐ Increase collaboration with the policing system |
| ☐ Do not know |
| ☐ Other: |

| **17. Please tell us about any other problems or gaps in services not mentioned above.** |
|---|
| |

**PART 2: INCREASING ACCESSIBILITY**

**This section is meant to identify strategies, practices and policies that could potentially encourage immigrant South Asian women survivors of domestic violence to access healthcare support/police protection services.**

| **18. Has your agency/service discussed the need to increase accessibility in your community?** |
|---|
| ☐ Yes |
| ☐ No |
| ☐ Do not know |
| ☐ Not applicable |
| ☐ Other |

| **19. If no, what are some of the reasons for it?** |
|---|
| (1 = Most important) |
| |
| ☐ Lack of knowledge and expertise to assists immigrant South Asian women on this issue |
| ☐ Insufficient staff and/or resources |
| ☐ Lack of awareness within our agency |
| ☐ Community does not have immigrant South Asian people |
| ☐ There are settlement/multicultural services in our community to provide the needed services |
| ☐ Other: |

| **20. What types of services and resources can assist service providers to more effectively respond to immigrant South Asian women impacted by domestic violence?**<br>(1 = Most important) |
|---|
| ☐ Accessibility to agencies with trained workers to provide support, safety planning and appropriate interventions in cases of domestic violence |
| ☐ Information on the vulnerabilities faced by women and reasons why immigrant south Asian women do not readily seek police protection for domestic violence |
| ☐ Information on the vulnerabilities/barriers facing women when deciding to disclose domestic violence to healthcare practitioners |
| ☐ Information on the connection between help-seeking decisions and domestic violence against women |

| |
|---|
| ☐ Information on critical entry points within healthcare and policing services to support women |
| ☐ A clear understanding of the risk indicators for domestic violence specific to immigrant South Asian women |
| ☐ Information on available community resources for purposes of referral and safety planning |
| ☐ Inclusion of information on dynamics and risk indicators of domestic violence in the context of increasing accessibility to healthcare and police protection in existing training materials |
| ☐ Policy and practice protocols to guide your work |
| ☐ Information on strategies for police and healthcare systems to increase the safety of women |
| ☐ Comment: 500 characters |

| **21**. **Are services/agencies in your community adequately funded to provide support and intervention in cases of domestic violence experienced by immigrant South Asian women?** |
|---|
| ☐ Yes |
| ☐ No |
| ☐ Do not know |
| ☐ Not applicable |

| **22**. **Which of the following strategies and practices does your program currently use to increase accessibility for immigrant, marginalized or isolated women accessing your services (please check all that apply)** |
|---|
| ☐ Make information available on the services provided by your agency, including risk assessment and safety planning, and in a variety of ways (e.g. printed materials like posters and brochures, website, social media, information tables etc.) |
| ☐ Make information available in diverse languages and at different locations in the community such as schools, in news bulletins and in local papers and language appropriate media |
| ☐ Provide outreach to isolated and marginalized populations in innovative ways, such as having a satellite office or staff available in close geographic proximity to the women |
| ☐ Make appropriate referrals to services within your community or sector |
| ☐ Make efforts to increase coordination for services in order to encourage appropriate and timely referrals (e.g. hospitals, family doctors, victim services, police protection and community services) |
| ☐ Provide assistance with transportation |
| ☐ Liaise with school, college, or university-based violence prevention programs |
| ☐ Generate or assist media coverage (e.g. newspaper articles, television, radio) |
| ☐ Other: |

| **23**. **What would you like to see implemented to help your program/community to better serve immigrant South Asian women at risk of domestic violence and in need of healthcare and policing services?** |
|---|
| (1 = Most important) |
| |
| ☐ Awareness programs/services in the community (community education/awareness) |
| ☐ Education programs in schools, colleges and universities |
| ☐ Community leaders speaking out |
| ☐ Religious leaders speaking out |
| ☐ Outreach workshops on healthcare and police services |
| ☐ Information on the medical effects of domestic violence on families, women and children |

| |
|---|
| ☐ All of the above |
| ☐ Comment: 500 characters |

| **24. What government (federal, provincial, municipal) policies or practices are challenges to supporting and serving your clients accessing healthcare and policing services? (please check all that apply)** |
|---|
| ☐ Accessing appropriate information about help-seeking needs of immigrant South Asian women |
| ☐ Accessing culturally competent training |
| ☐ Accessing trauma informed/trained healthcare services |
| ☐ Accessing well-informed and trained police officials |
| ☐ Accessing federal government for assistance |
| ☐ Immigration policies that protect clients without immigration status or non-residents |
| ☐ Policies related to provincial services |
| ☐ Lack of culturally competent and integrated services for healthcare and policing responses |
| ☐ Other: |

### i. ACCESSING HEALTHCARE

| **25. What are some challenges that women face when accessing medical services when experiencing domestic violence? (i.e. in case of injuries, multiple visits, or emergency services)** |
|---|
| ☐ Not believing victim/survivor |
| ☐ Lack of attention to victim safety |
| ☐ Lack of attention to physical needs |
| ☐ Lack of trauma informed response |
| ☐ Breaching privacy/confidentiality |
| ☐ Lack of transport |
| ☐ Lack of interpretation/translation services |
| ☐ Distance from services |
| ☐ Inadequate services (services not available or limited availability) |
| ☐ Lack of referrals/inappropriate referrals |

| **26. What are challenges women face when accessing GP/family doctors/other healthcare response in your community?** |
|---|
| ☐ Not believing victim/survivor |
| ☐ Lack of attention to victim safety |
| ☐ Lack of attention to physical needs |
| ☐ Lack of trauma informed response |
| ☐ Breaching privacy/confidentiality |
| ☐ Lack of transport |
| ☐ Distance from services |
| ☐ Inadequate services (services not available or limited availability) |
| ☐ Lack of referrals/inappropriate referrals |
| ☐ Disclosure in the presence of family members |

### ii. ACCESSING POLICE SERVICES

| **27. What do you believe are challenges for women seeking police protection?** |
|---|
| ☐ Not believing victim/survivor |
| ☐ Lack of attention to victim safety |
| ☐ Lack of attention to physical needs |
| ☐ Lack of trauma informed response |
| ☐ Breaching privacy/confidentiality |
| ☐ Lack of transport |
| ☐ Lack of interpretation/translation |
| ☐ Distance from services |
| ☐ Inadequate services (services not available or limited availability) |
| ☐ Lack of referrals/inappropriate referrals |

| **28. Please tell us about any promising or good practices in relation to the following areas of response to domestic violence and immigrant south Asian women accessing medical services** |
|---|
| |

| **29. Please tell us about any promising or good practices in relation to the following areas of response to domestic violence and immigrant south Asian women accessing police services** |
|---|
| |

| **30. Please tell us anything about the response to domestic violence experienced by immigrant South Asian women in your community that we have not asked about, but you think it would be important for us to know.** |
|---|
| |

**Reference:**

**Enhancing Community Capacity to Forced Marriages Project, Ending Violence Association of BC, MOSAIC, June 2015**

MONASH University

**SERVICE PROVIDERS FOCUS GROUP QUESTIONS**

Welcome and opening explanations.

This focus group is for service providers/management and policy makers working in the area of domestic violence in their intimate relationships and their work to support immigrant South Asian women in BC.

The objective of the focus group is to elicit information about the your expertise of providing services and working with guidelines for immigrant South Asian seeking medical attention and police help, what has been helpful, what is missing and what can be done to improve these services and support in British Columbia.

Definitions of South Asian and domestic violence for the purpose of this study:

**South Asian**: women with roots from the Indian subcontinent including India, Pakistan, Bangladesh, Nepal, and Tibet.

**Domestic violence:** physical, psychological, emotional, financial, verbal, or spiritual.

**Questions:**

**General Interventions/responses to domestic violence**

What are effective interventions for all women seeking healthcare and police response in situations of domestic violence in BC?

1. Are these interventions sufficient in meeting the needs of women in these situations?
2. Are there specific interventions in place in the healthcare and police systems to assist immigrant South Asian women in BC?
3. What are effective healthcare interventions for immigrant South Asian seeking healthcare in BC?
4. What are effective police interventions to increase the safety of immigrant South Asian women?
5. How do persons threatened with domestic violence deal with their family and social circle, when deciding to seek healthcare and police help?
6. How effective are government responses/policies in BC to immigrant South Asian women?
7. How do healthcare/police/RCMP perceive immigrant South Asian women?
8. What type of assistance do healthcare/police/RCMP offer women who are threatened with or who are victims of domestic violence?
9. What are some gaps/barriers preventing them from seeking healthcare or police help?

10. What protocols/policies guide service providers within your sector when responding to disclosure/reporting domestic violence?
    a. Can you provide us with a copy or advise us as to where we can obtain more information?
    b. Are these sufficient? If no, what materials/resources/ opportunities do you think would be useful in assessing risk and improving safety?
11. Are there any promising practices/policies that are emerging in your sector in identifying and responding to cases of immigrant South Asian women?
12. What recommendations can you make to improve and enhance healthcare and police help-seeking by immigrant South Asian women in BC?
13. Is there anything you have thought of that I should have asked?
14. Is there anything you would like to add?

Thank you

**If you have any questions, please do not hesitate to contact Harjit Kaur, Researcher, at hkau7@student.monash.edu or call her at 604-613-6583.**

MONASH University

**FOCUS GROUP QUESTIONS**

Welcome and opening explanations.

This focus group is for immigrant South Asian women who have experienced domestic violence in their intimate relationship.

The objective of the focus group is to elicit information about the your experience of seeking medical attention and police help, what was helpful, what was missing and what can be done to improve these services and support for immigrant South Asian women in British Columbia.

Definitions of South Asian and domestic violence for the purpose of this study:

**South Asian**: women with roots from the Indian subcontinent including India, Pakistan, Bangladesh, Nepal, and Tibet.

**Domestic violence:** physical, psychological, emotional, financial, verbal, or spiritual.
As you know, everyone participating in this group is an immigrant South Asian woman who has experienced domestic violence in her relationship. We are here to learn about your experiences when you disclosed this to a support person, healthcare practitioner: a nurse or doctor/or called the police for help.

**Questions:**

1. Thinking back to the time when you first told someone what had happened, what were some things that made it possible for you to talk about the domestic violence?
2. Was this the first time you experienced domestic violence in your relationship? **Yes/No**
3. Who did you first disclose the violence to?
4. What were some things that they said or did that were helpful?
5. What were some things that stopped you from disclosing the violence earlier?
6. What were some things they said or did that were not so helpful?
7. Did you seek **healthcare (medical attention)** after the first domestic violence incident? **Yes/No**
8. Did you disclose the reason for your visit/injuries? Who did you disclose to?
9. What were some things or reasons that made it easier to disclose the reason for your visit or injuries?
10. What were some things or reasons that stopped you from getting medical attention or disclosing to a healthcare practitioner?

11. What do you think healthcare practitioners can do to improve services for immigrant South Asian women experiencing domestic violence?
12. Did you seek **police assistance** after the first incidence of domestic violence? **Yes/No**
13. What were some things the police did or said that made you feel safer?
14. Were there things that the police did or said that were not helpful for you?
15. What can the police do to improve services for immigrant South Asian women?
16. Would you recommend other immigrant South Asian women seek police help when they experience violence?
17. Were there **other supports** that were helpful for you? (family/ friends/ community services/settlement services/ELS classes/school/college/university).
18. Is there anything you have thought of that I should have asked?
19. Is there anything you would like to add?

Thank you

## Appendix D. Recruitment Flyers

MONASH University

**Invitation to participate in Research Study**

**Healthcare and Police Response to Domestic Violence against Immigrant South Asian Women in BC**

**Purpose of research:**

Understand healthcare and police experiences of immigrant South Asian women in BC in order to improve their safety and access to services in situations of domestic violence.

You are invited to share your experiences about what is working, what is not working and what can be improved.

Join us if you:

- Can speak English
- Are an immigrant South Asian women who have experienced domestic violence
- Can attend an hour session during office hours on **Thursday, June 16, 2016 from 11 – 12 noon at the _____.**
- Willing to answer a series of questions about your own experience

We will:

- Compensate you for mileage at .44 cents/km or transit fare
- Provide a $20 gift card for your participation

**If you are interested to participate or have any questions, please do not hesitate to contact the researcher:**

**Harjit Kaur, Phd Candidate,**

Monash University, Department of Nursing & Midwifery

**Phone: 604 613 6583**

**Email: hkau7@student.monash.edu**

**Invitation to participate in Research Study**

**Healthcare and Police Response to Domestic Violence against Immigrant South Asian Women in BC**

**Purpose of research:**

Understand healthcare and police experiences of immigrant South Asian women in BC in order to improve their safety and access to services in situations of domestic violence.

You are invited to share your experiences about what is working, what is not working and what can be improved.

Join us if you:

- Can speak English
- Are an immigrant South Asian women who have experienced domestic violence
- Can attend an hour session during office hours on **Wednesday, May 25, 2016 from 10 – 11 am at the _____.**
- Willing to answer a series of questions about your own experience

We will:

- Compensate you for mileage at .44 cents/km or transit fare
- Provide a $20 gift card for your participation

**If you are interested to participate or have any questions, please do not hesitate to contact the researcher:**

**Harjit Kaur, Phd Candidate,**

Monash University, Department of Nursing & Midwifery

**Phone: 604 613 6583**

**Email: hkau7@student.monash.edu**

**Invitation to participate in Research Study**

**Healthcare and Police Response to Domestic Violence against Immigrant South Asian Women in BC**

**Purpose of research:**

Understand healthcare and police experiences of immigrant South Asian women in BC in order to improve their safety and access to services in situations of domestic violence.

You are invited to share your experiences about what is working, what is not working and what can be improved.

Join us if you:

- Can speak English
- Are an immigrant South Asian women who have experienced domestic violence
- Can attend an hour session during office hours on **Thursday, May 19, 2016 from 10 – 11 am at the** _____
- Willing to answer a series of questions about your own experience

We will:

- Compensate you for mileage at .44 cents/km or transit fare
- Provide a $20 gift card for your participation

**If you are interested to participate or have any questions, please do not hesitate to contact the researcher:**

**Harjit Kaur, Phd Candidate,**

Monash University, Department of Nursing & Midwifery

**Phone: 604 613 6583**

**Email: hkau7@student.monash.edu**

**Invitation to participate in Research Study**

**Healthcare and Police Response to Domestic Violence against Immigrant South Asian Women in BC**

**Purpose of research:**

Understand healthcare and police experiences of immigrant South Asian women in BC in order to improve their safety and access to services in situations of domestic violence.

You are invited to share your experiences about what is working, what is not working and what can be improved.

Join us if you:

- Can speak English
- Are an immigrant South Asian women who have experienced domestic violence
- Can attend an hour session during office hours on **Tuesday, July 19, 2016, 2 – 3 pm at the** _____
- Willing to answer a series of questions about your own experience

We will:

- Compensate you for mileage at .44 cents/km or transit fare
- Provide a $20 gift card for your participation

**If you are interested to participate or have any questions, please do not hesitate to contact the researcher:**

**Harjit Kaur, Phd Candidate,**

Monash University, Department of Nursing & Midwifery

**Phone: 604 613 6583**

**Email: hkau7@student.monash.edu**

# Appendix E. Ethics

MONASH University

**Monash University Human Research Ethics Committee (MUHREC)**
Research Office

**Human Ethics Certificate of Approval**

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

| | |
|---|---|
| **Project Number:** | CF15/4343 - 2015001875 |
| **Project Title:** | Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model. |
| **Chief Investigator:** | Prof Wendy Cross |
| **Approved:** | **From:** 15 March 2016 **To:** 15 March 2021 |

---

**Terms of approval** - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Professor Nip Thomson
Chair, MUHREC

**Human Ethics Office**
Monash University
Room 111, Chancellery Building E
24 Sports Walk, Clayton Campus, Wellington Rd, Clayton VIC 3800, Australia
Telephone +61 3 9905 5490 Facsimile +61 3 9905 3831
Email muhrec@monash.edu http://intranet.monash.edu.au/researchadmin/human/index.php
ABN 12 377 614 012 CRICOS Provider #00008C

MONASH University

Professor Wendy Cross
Head of School

21 August 2015

To Whom It May Concern:

***Re: Approval of proposed PhD project: Harjit Kaur***

I am writing in my capacity as the Principal Supervisor for Harjit Kaur, who has applied to undertake a PhD at Monash University, entitled, "*Creating Safety: Intersection Of Healthcare And Police Response To Violence Against Immigrant South Asian Women In British Columbia: A Service Provision Model".*

I have reviewed this project proposal and approve it as the program of PhD study to be undertaken by Harjit Kaur at Monash University.

Yours sincerely

Professor Wendy Cross
Head of School
School of Nursing and Midwifery

**School of Nursing and Midwifery**
Faculty of Medicine, Nursing and Health Sciences
Monash University, Building 13, Wellington Road
Clayton VIC, 3800, Australia
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## Appendix F. VAWIR Policy and Summary Domestic Violence Risks Factors


**INFORMATION BULLETIN FOR VICTIM SERVICE WORKERS**

**PROTOCOL FOR HIGHEST RISK DOMESTIC VIOLENCE CASES (VAWIR POLICY)**

**What is the Protocol for Highest Risk Cases?**

The Protocol for Highest Risk Cases forms part of the Violence Against Women in Relationships (VAWIR) policy. The VAWIR policy sets out the roles and responsibilities of service providers across the justice and child welfare systems who respond to domestic violence.

The Protocol for Highest Risk Cases is new and supplements other sections of the VAWIR policy. The protocol outlines the responsibilities of justice and child welfare partners for the delivery of a coordinated response to cases designated by police as at highest risk for serious bodily harm or death.

A key objective of this protocol is enhanced case coordination and information sharing among justice and child welfare partners and the key responsibilities in this regard are highlighted in this bulletin. For complete details, please refer to the full Protocol for Highest Risk Cases contained in the VAWIR policy.

**Why was a Protocol for Highest Risk Cases developed?**

While all domestic violence incidents are concerning, certain cases pose a greater risk of violence resulting in serious bodily harm or death. Over the years numerous reports, inquests and inquiries into domestic violence incidents have outlined the need to enhance coordination, safety planning and risk management strategies in these cases. The protocol was developed in recognition of the need for increased collaborative action among justice and child welfare partners in domestic violence cases of the highest risk.

Information sharing is integral to enhanced coordination and collaboration in highest risk cases. The protocol was designed to facilitate the flow of critical information to support informed and effective decision making in highest risk cases. For example, identification and communication of relevant information regarding risk factors and safety concerns can:

- assist Crown counsel in identifying the appropriate conditions to seek on a bail order;
- aid victim service workers in developing suitable safety plans;
- inform Corrections staff's supervision and monitoring strategies; and
- assist child welfare workers in their safety assessments and planning for children exposed to violence.

Ensuring that relevant and critical information is available to justice and child welfare partners involved in highest risk cases is essential to facilitating an effective response and protecting the victim and others at risk for violence or death.

**Who are the justice and child welfare partners in this protocol?**

Partners in this coordinated response to highest risk cases include:

- Police
- Crown counsel
- Corrections staff (bail supervisors and probation officers)
- Victim service workers
- Child welfare workers

The protocol also acknowledges that it is important for these identified partners to work collaboratively with other allied service providers (e.g. transition house programs, stopping the violence counselling and outreach programs, health services, immigrant and settlement services) in order to ensure a comprehensive response.

**What are the responsibilities of justice and child welfare partners in this protocol?**

**Police**

For the purpose of this protocol, the designation of highest risk is assigned by the police when they believe there is significant potential for serious bodily harm or death.

The highest risk designation is assigned by police on a case by case basis according to their professional judgment, training (including the course “Evidence- based, Risk-focused Domestic Violence Investigations”) and experience. Police officers may use a tool such as the Summary of Domestic Violence Risk Factors (see Appendix) to analyze the risk factors present. Where it is determined that a case may be highest risk, the police officer will refer the case to a supervisor or specialized investigator for further review. A formal B-SAFER risk assessment is strongly encouraged for cases that may be highest risk; however, if not undertaken an analysis of relevant risk factors is still important to promote consistency in risk assessment and the identification of highest risk cases at the earliest opportunity.

Once a case is identified as highest risk, police ensure that the other partners in the protocol are notified of the designation and that enhanced provisions for information sharing and case management are required in accordance with the protocol.

Where children are involved (whether present at the time of the incident or not), police are responsible for reporting the incident to a child welfare worker. Police are also to proactively refer victims in highest risk cases to victim services and ensure they are contacted to canvas safety concerns, and to be advised of the status of the investigation and highest risk designation.

Throughout the course of a case designated as highest risk police are responsible for ensuring that Crown counsel, victim service workers, child protection workers, and Corrections staff involved in the case are provided with contact information for each other and updated on information concerning the incident, the

highest risk designation, identified risk factors, detention or release of an accused including conditions of release, breaches, new charges and court dispositions.

**Crown Counsel**

In all cases where the file has been identified as highest risk by police, domestic violence charges are assessed on a priority basis and a heightened response should be implemented in recognition of the inherent danger and risk of future harm that is often associated with these cases.

When assessing the Crown's position on bail for an accused, Crown counsel should have particular regard for the safety of victims and other family members, especially children, and must consider all available, reliable information regarding the risk presented by the accused. When Crown counsel has reason to believe that additional relevant information is available, they request it from the police before making submissions on a bail hearing and ask for a remand under s. 516(1) if necessary.

If Crown counsel determines that a detention order is not necessary or that the conditions of bail recommended by the police are not necessary, they should consult with police before making the final decision on the Crown's position at the bail hearing and should ask police whether there is any further relevant information or evidence to consider.

In a highest risk case, if a bail hearing is held and the accused is released from custody Crown counsel (or designated Crown personnel) are to notify the victim and police of the release and conditions of release as soon as possible. Police will then notify the other partners.

When such a case has been concluded, Crown counsel (or designated Crown personnel) will notify the victim and police of the court disposition (e.g. conviction, stay, acquittal) and police will notify the other partners.

**Corrections staff**

Upon receipt of notification that a case has been designated highest risk, bail supervisors/probation officers make efforts to contact the victim and others protected by a bail order or community supervision order to explain the conditions, the process to report breaches and reinforce the need to develop a safety plan.

Adherence of the accused to court imposed conditions of bail or sentenced orders are monitored and enforced by bail supervisors/probation officers. Where there is information concerning breaches of orders that are relevant to victim safety in a highest risk case (e.g.breaches of protective conditions, failure to report), Corrections staff share this information with the other partners and the victim.

**Victim Service Workers**

When notified by police that a case is highest risk, victim service workers will immediately prioritize the case to ensure a heightened response. They are to connect with the victim on a priority basis to provide relevant supports including safety planning and emotional support.

In a highest risk case, victim service workers will inform identified justice and child welfare partners of any additional support needs a victim requires to address specific language, cultural or immigration factors. Victim service workers will work with police and the victim to ensure copies of protection orders related to children are provided to the child's school and/or daycare.

Where appropriate, victim service workers will forward an application for benefits on behalf of the victim to the Crime Victim Assistance Program (CVAP), indicating that the case has been designated as highest risk by the police, and follow-up with CVAP management.

**Child Welfare Workers**

In all cases designated as highest risk, the child welfare safety assessment, planning and intervention process is to begin right away to ensure that the child is safe.

Once notified of the designation, the child welfare worker will immediately contact the police to review relevant information.

Child welfare workers will provide information concerning the results of child welfare involvement to the police for dissemination to the other partners.

**How can these responsibilities be achieved?**

Utilizing standardized forms may be an effective way to facilitate case coordination and information sharing in highest risk domestic violence cases. The provincial government has developed two optional notification forms – a Designation Form and a Case Update Form – which are available at: www.pssg.gov.bc.ca/victimservices/publications. You may wish to use these forms or adapt them to best meet the needs of your community.

- **The Designation Form – Highest Risk Domestic Violence Cases** serves to notify Crown counsel, Corrections, Victim Services and Child Welfare that a case has been designated highest risk and provides partners in the protocol with relevant case information including the identified risk factors. When an agency receives this form, they should contact the police officer who sent the form and confirm or provide contact information for the staff member who is assigned to the case. This will assist in initiating coordination and ensuring that all partner agencies can be made aware of the appropriate contacts involved.
- **The Case Update Form – Highest Risk Domestic Violence Cases** can be utilized by any one of the identified justice and child welfare partners assigned to a case to provide important case updates. Updates may include such things as: information regarding a breach, the setting of a trial date or another significant circumstance such as relocation of the victim or accused. This form can serve as a formal mechanism for facilitating case management among justice and child welfare partners.

When significant events in a highest risk case occur (e.g. breach or new charges) consider coordinating either an in person meeting or conference call with identified justice and child welfare partners to support case coordination efforts to mitigate risk and identify safety strategies.

Consider meeting with justice and child welfare partners in your community to review the protocol. It may be helpful to agree to a standard format to facilitate case coordination and information sharing in designated highest risk domestic violence cases.

**Links**

The Violence Against Women in Relationships (VAWIR) policy, including the Protocol for Highest Risk Cases, and the optional notification forms can be found at:

www.pssg.gov.bc.ca/victimservices/publications/index.htm#domesticviolence.

# SUMMARY OF DOMESTIC VIOLENCE RISK FACTORS

*This is a summary of some of the risk factors that have been associated with an increased likelihood of future violence in relationships. This document is intended to assist police with conducting evidence-based, risk-focused domestic violence investigations.*

This icon indicates the risk factors that Police Officers must be aware of when conducting evidence-based, risk -focused Domestic Violence investigations.

This icon indicates a risk factor associated with the greatest potential for LETHAL violence.

This icon indicates a risk factor that if present must be included (at a minimum) in the documentation for a Bail Hearing.

| Legend | |
|---|---|
| | Indicates a risk factor associated with increased severity (escalation) of future violence. |

| 1. Relationship History | | |
|---|---|---|
| | **Current Status of the Relationship** | • Is there past, recent or pending separation in the relationship?<br>**Note:** Social science experts say that where there are controlling coercive behaviours, the intensity and lethality of violence often escalates after the victim leaves the relationship. |
| | **Escalation in Abuse** | • Is there escalation in the frequency/intensity of violence or abuse towards the complainant, family members, a pet or another person? |
| | **Children Exposed** | • Are there children, under 19 years of age, in the family who are living in the home?<br>• Who are the parents and is there a custody dispute? (**Note**: Contact the Ministry of Children and Family Development.) |
| | **Threats** | • Has the Suspect ever threatened to kill or harm the complainant, a family member, another person, children or a pet? |
| | **Forced Sex** | • Has the Suspect ever forced sex on the complainant? |
| | **Strangling, Choking or Biting** | • Has the Suspect ever strangled, choked or bit the complainant? |
| | **Stalking** | • Has the Suspect displayed jealous behaviours, stalked or harassed the complainant or a previous intimate partner? |
| | **Information on Relative Social Powerlessness** | • Are marginalization factors present (i.e. disability, immigrant or Aboriginal background, addiction, poverty, pregnancy, lack of transportation, literacy issues, mental illness, elderly etc.)?<br>• Are cultural factors present (i.e. family pressures/shame, religious beliefs, unwillingness to |

| | | |
|---|---|---|
| | | report, language barriers, isolation etc.)? |
| **2. Complainant's Perceptions of Risk** | | |
|  | **Complainant's Perception of Personal Safety** | • Does the complainant believe the Suspect will disobey terms of release particularly a no contact order? |
|  | **Complainant's Perception of Future Violence** | • Does the complainant fear further violence if the Suspect should be released from custody?<br>• What access is there to the Victim and what is the basis of the Victim's fear? |
| **3. Suspect History** | | |
|  | **Suspect's Criminal Violence History** | • Does the Suspect have a history of threats, violence, sex assaults, and criminal harassment?<br>**Note:** One of the most common research findings is that Offenders with a history of violence are much more likely to engage in future violence. |
|  | **Previous Domestic Violence History** | • Is there a history of stalking, violence or abusive behaviour in a previous Intimate Partner Relationship?<br>• Is there any history of threats or actual violence or abusive behaviour against children, other family members, friends, co-workers or family pets?<br>• Is there any history of stalking, threats or violence from the suspect, against other intimate partners of the complainant? |
|  | **Court Orders** | • Has the Suspect ever violated a Court Order?<br>• Is the Suspect presently bound by any Court Orders?<br>• Is the Suspect in a reverse onus situation for bail? |
|  | **Alcohol/Drugs** | • Does the Suspect have a history of drug or alcohol abuse? |
|  | **Employment Instability** | • Is the Suspect unemployed or experiencing financial problems? |
|  | **Mental Illness** | • Does the Suspect have a history of mental illness (e.g. depression or paranoia)? |
|  | **Suicidal Ideation** | • Has the Suspect threatened or attempted suicide? (If **YES**, when and how?) |
| **4. Access to Weapons/Firearms** | | |
|  | **Weapons/Firearms (Used or Threatened?)** | • Has the Suspect used or threatened to use a firearm or weapon against the complainant, family member, children or an animal? |
|  | **Access to Weapons/Firearms** | • Does the Suspect have access to weapons/firearms? |


Ministry of Public Safety and Solicitor General
Ministry of Attorney General
Ministry of Children and Family Development

# Violence Against Women in Relationships

# POLICY

December 2010

PSSG10-030

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# Table of Contents

# Introduction

## About this Policy

### Background

The ministries of Public Safety and Solicitor General, Attorney General, and Children and Family Development recognize that domestic violence constitutes a very serious and complex criminal problem.

The *Violence Against Women in Relationships* (VAWIR) policy was developed in 1993 to revise and expand the original 1986 Ministry of Attorney General Wife Assault policy. The policy has been updated several times over the years (1996, 2000 and 2004) to reflect applicable legislative changes (including Criminal Code and provincial legislation) and changes to operational policies.

This updated policy document fulfils a commitment under the province's Domestic Violence Action Plan. The action plan was launched in January 2010 in response to recommendations from the Lee/Park coroner's inquest and the Representative for Children and Youth's report on the death of Christian Lee. The focus of the action plan is enhancing and integrating the response to domestic violence by the justice system and child welfare partners to better serve all British Columbians.

The ministries of Public Safety and Solicitor General, Attorney General and Children and Family Development collaborated on the update of the provincial VAWIR policy.

Emerging best practices recognize the need for integrated cross-agency policies as a key component of an effective response strategy to domestic violence. The improved guidelines in this policy and the new protocol for highest risk cases reinforce the province's commitment to a multi-agency, co-ordinated response to domestic violence. All parties to this policy agree that minimizing the risk of violence, enhancing victim safety and ensuring appropriate offender management are priorities for the province.

### Definition

For the purposes of this policy, "violence against women in relationships" and alternative terms used when referring to "domestic violence" (including "spousal violence", "spousal abuse", "spouse assault", "intimate partner violence" and "relationship violence") are defined as physical or sexual assault, or the threat of physical or sexual assault against a current or former intimate partner whether or not they are legally married or living together at the time of the assault or threat. Domestic violence includes offences other than physical or sexual assault, such as criminal harassment, threatening, or mischief, where there is a reasonable basis to conclude that the act was done to cause, or did in fact cause, fear, trauma, suffering or loss to the intimate partner. Intimate partner relationships include heterosexual and same-sex relationships.

Domestic violence cases are designated as "K" files by Crown counsel. "K" files include cases in which the intimate partner is the target of the criminal action of the accused although not the direct victim; for example, where the accused has committed an offence against someone or something important to the intimate partner such as an assault on the intimate partner's child or new partner. Similarly, Crown counsel identify as "K" files charges arising from breaches of court orders and applications for section 810 recognizances relating to domestic violence cases.

The title of this policy, *Violence Against Women in Relationships*, is meant to acknowledge the power dynamics involved in these cases. It recognizes that most of these offences are committed by men against women and that women are at a greater risk of more severe violence.

Nonetheless, the VAWIR policy applies equally in all domestic violence situations regardless of the gender of the offender or victim. The policy is equally intended to stop violence in both same-sex relationships and violence against men in heterosexual relationships.

For brevity, the terms "domestic violence" and "spousal violence" appear throughout this document.

"K" files include cases in which the intimate partner is the target of the criminal action of the accused although not the direct victim.

## Purpose of VAWIR Policy

This policy sets out the protocols, roles and responsibilities of service providers across the justice and child welfare systems that respond to domestic violence. It also reflects the operational policies of the various agencies involved.

The primary purpose of the VAWIR policy is to ensure an effective, integrated and co-ordinated justice and child welfare response to domestic violence. The goal is to support and protect those individuals at risk and facilitate offender management and accountability.

This policy is also intended to provide the public with information about the complex criminal issue of domestic violence, including the roles and responsibilities of justice and child welfare system partners.

While the VAWIR policy focuses on the justice and child welfare response to domestic violence, collaboration with allied service providers is vital to ensure a comprehensive response. When appropriate, collaboration with and referrals to and from service providers help ensure that victims of domestic violence are effectively supported in a co-ordinated fashion. Service providers include: transition house programs, stopping the violence counselling programs, children who witness abuse programs, outreach and multicultural outreach services, health services, and immigrant settlement services.

Developing and maintaining positive working relationships among service providers in the justice, child welfare, health, housing and social service sectors is key to ensuring that victims of domestic violence are well supported. This may include partnering with local service providers on innovative approaches to co-ordination through developing projects or processes that are supported by protocols or memorandums of understanding.

# Setting the Context

## Dynamics of Domestic Violence

In domestic violence situations, violence is commonly used by one person to establish control over their partner or to control their partner's actions. These tactics are often successful because of the fear and isolation a victim feels.

No matter which form it takes, the dynamics of abuse in domestic violence situations differ significantly from other crimes. The victim is known in advance, the likelihood of repeat violence is common and interactions between the justice system and the victim are typically more complex than with other crimes. Research indicates, for example, that 21 per cent of women who are spousal violence victims experience chronic assaults (10 or more).[1]

When violence occurs, there is usually a power imbalance between the partners in the relationship. It may be extremely difficult for a victim to leave the relationship due to feelings of fear and isolation as well as cultural/religious values, socio-economic circumstances, or even denial of the violence. Violence often escalates over time and may continue or even worsen if the victim attempts to leave the relationship causing the victim to stay or return. Similarly, concern for the safety of children may make it difficult for the victim to leave. The threat of violence to the children may be used by an abusive partner seeking power and control.

Despite the harm that the abuse may have caused and the risk of continued or more serious harm, the dynamics of the relationships in which these crimes arise may result in the victim's reluctance to fully engage with the police or Crown counsel in the investigation and prosecution of these crimes. Research suggests that nearly two-thirds of women (64 per cent) who are victims of a spousal assault do not report the violence to police.[2] There are a number of reasons, including fear of escalation in the violence or the potential for threats of violence directed toward children.

If a victim does become involved in the justice system, it is important to provide that individual with a full and sensitive explanation of the process. The importance of keeping the victim informed and supported throughout the situation should not be underestimated. This is especially true when children are involved. Justice system personnel proactively refer victims to available supports, including victim services and other community services, to ensure that victims have access to resources that keep them safe and allow them to effectively participate in the justice system.

Justice system personnel are trained on the power imbalance and dynamics that prevent a victim from taking steps to end violence. A vigorous approach to police investigation and subsequent legal response, promoted by this policy, are necessary to help prevent domestic violence in our society.

# Scope of the Domestic Violence Issue

Domestic violence has a significant and adverse impact on families and communities. While society has made important advances in addressing domestic violence, this issue remains a serious challenge in British Columbia:

1. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. p. 33.

2. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. pp. 16, 55.

- From 1999 to 2004, it is estimated that 183,000 British Columbians 15 years of age and over were victims of spousal violence.[3]
- Domestic violence cases constitute the most numerous case type for Crown counsel. In 2008/09, Crown counsel received 10,224 domestic violence cases (14 per cent of all cases received).[4]

## Children

Children who have been exposed to domestic violence are more likely to be abused or neglected in their family home. As adults, they are more likely to be in an abusive relationship as an aggressor or a victim.[5] From 1999 to 2004, more than three out of 10 victims in Canada reported that their children witnessed their abuse.[6]

## Women

The majority of domestic violence cases in the criminal justice system involve female victims. As a whole, women continue to be more adversely impacted by domestic violence than men. This view is supported by research findings that:

- The majority of victims of police-reported spousal violence continue to be women, accounting for 83 per cent of victims in 2007.[7]
- Women are more likely than men to be victims of spousal homicide. In 2007, almost four times as many women were killed in Canada by a current or former spouse as men.[8] Of the 73 domestic violence homicides occurring between January 2003 and August 2008 in British Columbia, 55 involved a female victim.[9]
- In domestic violence situations, women are more than twice as likely as men to be physically injured, three times more likely to fear for their lives and six times as likely to seek medical attention.[10]

## Groups at Increased Risk

Research shows that some groups of women are at greater risk of violence than others. Aboriginal women are more than three times as likely as non-aboriginal women to be victims of spousal violence, and are significantly more likely to report the most severe and potentially life-threatening forms of violence.[11] And, women under 25 years of age are at the greatest risk for spousal homicide.[12]

Research indicates additional factors intersect in women's lives to compound their experience of violence and abuse.[13] Immigrant and visible minority women who experience abuse from their partners are less likely to report it to the police and are often hesitant to use available support services, or be aware that they exist.[14] An immigrant who has not fully settled in Canada may be unfamiliar with laws, socio-cultural norms, their rights and responsibilities. They may lack social networks, and/or may have limited English language skills which may impact on their interactions in the justice system. Socioeconomic factors (poverty and homelessness), geography (rural isolation), and health factors (including mental health, addictions and physical disability) are commonly cited as affecting a woman's experiences of violence.

Throughout the VAWIR policy, justice and child welfare system partners are directed to be sensitive to the unique circumstances of victims of domestic violence.

3. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. p. 19.

4. Criminal Justice Branch (2010). *VAWIR Matters per Accused Person* – JUSTIN Data.

5. UNICEF et al. (2006). *Behind Closed Doors: The Impact of Domestic Violence on Children*. p. 3.

6. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. p. 19, 34.

7. Statistics Canada (2009). *Family Violence in Canada: A Statistical Profile*. p. 5.

8. Statistics Canada (2009). *Family Violence in Canada: A Statistical Profile*. p. 6.

9. British Columbia Coroners Service (2010). *Report to the Chief Coroner of British Columbia: Findings and Recommendations of the Domestic Violence Death Review Panel*. p. 3.

10. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. p. 33.

11. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. pp. 64-65.

12. Statistics Canada (2006). *Measuring Violence Against Women: Statistical Trends 2006*. pp. 36-37.

13. Johnson, Holly and Myrna Dawson (2010). *Violence Against Women in Canada: Research and Policy Perspectives*. Don Mills, ON: Oxford University Press.

14. Canadian Council on Social Development. (2004). *Nowhere to Turn? Responding to Partner Violence Against Immigrant and Visible Minority Women*. p. 34.

## How this Policy Document is Organized

This document is divided into 10 sections.

It begins with an introduction which includes the background of the policy, definition of Violence Against Women in Relationships, purpose of the policy and the broader context of the issue of domestic violence.

Individual sections focus on the roles and responsibilities of the service providers (one section for each, but all integrated). The last section sets out a protocol for the highest risk cases.

# Police

## Introduction

As first responders, police have a key and important leadership role in managing issues associated with keeping victims safe. Police assume a critical responsibility in identifying highest risk cases of domestic violence and initiating the flow of information and communication among response agencies.

Police are advised to consult this policy (including the *Protocol for Highest Risk Cases and Police Release Guidelines*) and their own department or detachment's operational policies and procedures.

## Response

Domestic violence incidents come to the attention of police by a variety of means. These include 911 calls (e.g., incident, breach), in person complaints, probation officers (e.g., breach), and referrals from other agencies (e.g., victim service programs, other police agency). A call may be from a victim, family member, or the public.

### Priority Response

Police calls involving domestic violence are a priority for assessment and response. These include all reported breaches of no-contact conditions of criminal orders, recognizances, and civil restraining orders.

Police respond to the location regardless of whether the call is disconnected, if the caller indicates police are no longer needed, or if the caller cancels the request on a follow-up call.

When a person attends a police station or detachment in-person alleging domestic violence, an officer should be assigned to investigate. The victim is not directed to return at another time, or to complete a written statement and return it later. The timeliness of the victim's report (e.g., several days after the event) does not lessen the severity of the incident and must not affect the police response. If the incident occurred in another police jurisdiction, the official receiving the complaint ensures a timely referral to the correct police agency.

Dispatch or other staff who take reports prioritize the safety of victims. As domestic violence calls constitute a high risk to responding officers, it is important to acquire as much information as possible regarding the situation and the individuals involved.

## Evidence-based, Risk-focused Investigations

Responding officers apply their knowledge of risk factors and their training,including the course "*Evidence-based, Risk-focused Domestic Violence Investigations*" to conduct an investigation. The risk factor categories are:

1. **Relationship history** (current status of relationship; escalation of abuse; children exposed; threats; forced sex; strangling/choking/biting; stalking; relative social powerlessness – marginalization and cultural factors);
2. **Complainant's perceptions of risk** (perception of personal safety/future violence);
3. **Suspect history** (previous domestic/criminal violence history; court order; drugs/alcohol; mental illness; employment instability; suicidal ideation);
4. **Access to weapons/firearms** (used/threatened; access to).

When a responding officer has concerns that a domestic violence case may possibly be highest risk based on their preliminary investigation, they contact their supervisor or a specialized investigator (Refer to the Protocol for Highest Risk Cases in this policy and operational policies).

The investigation process should not be influenced by the following factors:

- Relationship status or sexual orientation of the suspect/victim;
- Co-habitation of suspect and victim at the same premises;
- Preference by complainant that no arrest be made;
- Occupation, community status, and potential consequences of arrest;
- History of complainant including prior complaints;
- Verbal assurances that the violence will stop;
- Complaints about emotional state of the victim or suspect;
- Lack of visible injuries;
- Speculation that the complainant will not proceed to prosecution; and
- Intoxication/drug use by the victim.

## Primary Aggressor

When the parties allege mutual aggression, police fully investigate to determine what happened, who is most vulnerable, and who, if anyone, should be arrested. An allegation of mutual aggression may be raised by the primary aggressor as a defense with respect to an assault against their partner.

The practice of arresting both parties is discouraged. Police should conduct a primary aggressor analysis, and arrest the primary aggressor, where grounds exist, in accordance with the Criminal Code. The primary aggressor is the party who is the most dominant rather than the first, aggressor.

In determining the primary aggressor, police should consider all the circumstances, including the following questions:

- Who has superior physical strength, ability and means for assault and/or intimidation?
- What is the history and pattern of abuse in the relationship and in previous relationships?
- Who suffered the most extensive physical injuries and/or emotional damage and who required treatment for injury or damage?
- Are there defensive wounds?

### Entry

Where police have reasonable certainty that the ongoing safety of individuals within a premises is in jeopardy, police have limited authority to forcibly enter a premise to ensure the safety of all parties. They do not take the word of any single occupant with regard to safety, but speak to all occupants. The specific authority to enter a premise to check on the safety of occupants is found in the 1998 Supreme Court of Canada decision (R. v. Godoy).

### Suspect Departed Scene

When a suspect has departed the scene prior to police arrival, police assess the likelihood of the suspect's return and take steps to ensure victim safety. Police make immediate efforts to locate and arrest the suspect where there are grounds. They also complete a Report to Crown Counsel with a request for an arrest warrant. When appropriate, police enter the suspect on CPIC as arrestable.

### Children Present

As part of the initial investigation, the responding officer determines whether there are children in the relationship, if they were present during any of the reported incidents, and if they have been the victim of violence.

If a child is in immediate danger or a criminal offence against a child is suspected. police should immediately notify a child welfare worker.

When children are involved, an officer's risk analysis and best judgment determines if a child is in immediate danger or a criminal offence against a child is suspected. The officer immediately contacts a child welfare worker to request their attendance. The child welfare worker's response is in accordance with their policy. If the child welfare office is not open, police call the After Hours Helpline for Children (310-1234) and indicate on the police incident/occurrence report and the Report to Crown Counsel that a child welfare worker was notified.

The child welfare worker speaks with the parent, and the child if possible, and makes arrangements with the police to ensure that the child is safe. This may include returning the child to the victim parent at a safe location, taking the child to a safe place identified by the victim parent, or taking the child to another safe place.

If a situation affecting children is of an immediate serious nature and a child welfare worker is not readily available, police "take charge" of the children under section 27 of the Child, Family and Community Service Act (parental consent is not required).

When children are involved and an officer's analysis of risk factors and best judgment determines a situation is not at the highest level of risk, the immediate attendance of a child welfare worker is not required. Prior to end of shift the incident is reported to a child welfare worker by notifying the child welfare office or the After Hours Helpline for Children (310-1234). A child welfare worker attends within legislated timelines.

Police should include their name on the incident/occurrence report to the child *welfare worker as well as the following information (Refer to BC Handbook for Action on Child Abuse and Neglect: What to Report,* page 42): www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf

- Details of the incident — what occurred, where, who was present (names, ages, addresses)?
- Does the suspect have a police history of violence?
- Is the risk assessment completed, or is the file being sent to a domestic violence unit?
- Were injuries sustained?
- Was there medical follow-up?
- Have police been to the location before. If so, when?
- Are there protection orders in place?
- What is the current location of the suspect, victim, and children?
- Were weapons used?
- Have children been interviewed or will they be interviewed, by police?
- Are charges being forwarded to the Crown?
- Is there sufficient information for the child welfare worker to assess whether it is safe for them to interview the suspect?

If children are out of the home when a police response occurs, the officer, working in partnership with the child welfare worker, takes steps to locate the children and ensure their safety (as well as that of any other individuals at the children's location).

When a criminal offence related to child abuse or neglect may have occurred, police thoroughly investigate the allegations and the potential for charges, in collaboration with a child welfare worker.

In instances when children are involved, whether they were present or not at the time of the incident, police record in their incident/occurrence report the date, time, and name of the child welfare worker with whom they spoke.

Police also ascertain if the suspect threatened to remove or harm the children as a tactic of control/intimidation.

A police interview of victims. child witnesses or family members must not occur in the presence of a suspect.

## Firearms

Police query the victim to determine if the suspect owns or has access to firearms and check the Canadian Firearms Registry. If firearms are present, police may seize weapons (with or without warrant, including firearms-related certificates, licenses, permits and authorizations) and do so regardless of whether the suspect has used/threatened to use them. Accordingly, police ensure that they fulfill legal obligations outlined in Criminal Code sections 109 to 117.15 and the Firearms Act and its regulations.

Police should keep the following procedures in mind:

- Apply for parallel (to the substantive offence) section 111 applications for firearms prohibitions, making a note on the substantive file that such an application is being made;
- Personally accompany the accused, to seize firearms and all possession and acquisition licenses, in cases when the term of an 11.1 Undertaking To Appear is to surrender such items;
- Release the suspect on recognizance with a firearms prohibition and certificate surrendering condition;
- If releasing a suspect on bail with a firearms prohibition, ensure conditions require the accused to immediately surrender any firearms to police;
- Log incident in police department records; and
- Forward information regarding seized firearms to Crown counsel on an urgent basis. There is a 30-day time limit for commencing proceedings after which it is mandatory to return the firearms.

### Evidence

When it has been established that an offence has occurred, police should document all evidence and provide Crown counsel with a complete written record even when the victim is reluctant to cooperate with the investigation. Police work to build a case that can stand independent of the victim testimony, taking accurate and detailed notes on the incident. Police should provide 911 tapes.

### Breach of Conditions

Alleged breaches of conditions of criminal and civil orders require assessment, no matter how minor, including those reported to police for investigation by bail supervisors/probation officers. Breach of conditions may result from direct or indirect contact (e.g., phone calls, text messages, e-mails, messages sent via friends) depending on the wording of the condition.

When a breach relates to an existing order on a domestic violence case, police should not release but hold the accused for court. The victim should also be notified by police.

Police ensure that all relevant information regarding the breach (including risk assessment information) is shared on a priority basis with bail supervisors/probation officers and appropriate contacts from child welfare.

Charges should always be considered where a breach leads to a concern about victim safety.

If the accused is on any form of bail and has breached the current bail conditions, or if an officer's best judgment determines there are reasonable and probable grounds to believe the accused has or will commit an indictable offence, the accused is in a position where he/she must justify their release. (Refer to Criminal Code section 524.) A remand should be sought pursuant to Criminal Code section 516(1). This may be referred to as a reverse onus situation.

A Report to Crown Counsel, even if a preliminary report, must be provided for the bail hearing.

If the terms of an order under the Child, Family and Community Service Act or the Family Relations Act (family court) conflict with those of a criminal court order, the more restrictive terms of the criminal court order are paramount. For example, if

a criminal order prohibits contact with the spouse while a corresponding family order grants access to the children, the accused is prohibited from contacting the spouse (according to the criminal order) even for the purposes of obtaining access to the children.

The Child, Family and Community Service Act or family court order terms not superseded by the criminal court order continue to be in effect. In some cases the Child, Family and Community Service Act order may contain no contact provisions regarding the children while the criminal order is silent on that issue. Upon expiration of a criminal order all of the terms of any valid Child, Family and Community Service Act and family court orders remain in effect.

The Child, Family and Community Service Act order is paramount when the terms of an order under the act conflict with those of a family court order.

If a Child, Family and Community Service Act or family court order includes terms prohibiting contact or communication to protect a person that are more restrictive than the criminal court order, the accused must abide by both orders and both orders are to be enforced. For example, a criminal court order restricting contact between spouses while a concurrent protection order under the Child, Family and Community Service Act or family law restricts contact with the spouse and children.

A Report to Crown Counsel must be provided for the bail hearing.

### Contact Information

Police should always provide the victim with the investigating officer's name, case number, and follow-up contact numbers.

## Arrest

Comprehensive and accurate documentation are critical elements in the investigation and prosecution of all cases. Police ensure all documents pertaining to the events and circumstances justifying an arrest are completed in this manner.

Police should ensure the file is appropriately denoted as domestic violence in all relevant documents (including Report to Crown Counsel, police files, incident/occurrence report) and justice databases (including PRIME), consistent with operational policies.

When an indictable offence has occurred, or may occur, police should arrest the suspect without warrant under section 495 of the Criminal Code to:

- Protect the public interest;
- Ensure victim safety;
- Prevent a repeat offence or the commission of new offences (i.e., interference with administration of justice, witness intimidation);
- Secure attendance of the accused in court; and
- Preserve evidence.

Police decisions to recommend charges must not be influenced by factors such as:

- Relationship status/co-habitation of the parties;
- Previous police calls involving the same victim/suspect;
- Verbal assurances by either party that the violence will cease;

- Gender, race, ethnicity, disability, sexual orientation, occupation, socio-economic status of the suspect;
- Denial by either party that the violence occurred;
- Reluctance to proceed on the part of the victim.

Upon arrest and prior to setting release or bail conditions, police should assess victim safety needs to determine whether to release or detain a suspect.

## Release, Bail, Detention

After arresting a suspect the following actions may occur:

**Released on appearance notice or summons**

It is not typically in the public interest to release an accused on an appearance notice or summons because no bail conditions can be attached to this form of release. Police must be satisfied the accused poses no risk of violence or intimidation to victims or witnesses.

**Released by a police officer on conditions**

Criminal Code sections 497-499 and 503 permit police to release accused persons on undertakings and recognizances with specific conditions. (Refer to APPENDIX ONE – Police Release Guidelines.)

**Police release occurs by having the accused enter into an undertaking according to Form 11.1 —** Undertaking Given to a Peace Officer or Officer in Charge

The undertaking may include the following available conditions:

- Abstain from communicating, directly or indirectly, with any victim and children, witness (including children) or other person identified in the undertaking;
- Identify all persons, including children — names to be used where possible. If the names are unknown, an identifying description is reported such as "the family of Jane Doe/John Smith including their mother, father, child, brother and sister";
- Consider including the names of the victim's children and other family members, or any other person who may be subject to intimidation or undue pressure;
- Do not attend the family residence, victim's place of work, children's school/daycare, or other place where the accused knows that people named in the non-communication order could be found. *Note:* Places are specified by an area restriction or a specific address. Caution is used to avoid providing the accused with unknown information regarding the whereabouts of a victim/witness.
- Report to a bail supervisor at a designated location at specified times and as directed thereafter by the bail supervisor. This condition should always be applied in domestic violence cases;
- Abstain from possessing firearms, surrender firearms in their possession, and surrender authorizations, licenses, and registration certificates to acquire or possess firearms. *Note:* When a suspect on bail with a firearms prohibition is released, police ensure conditions are upheld that require that the accused surrender firearms to the police immediately and not at a later date;

- Abstain from consuming alcohol and drugs;
- Comply with other conditions that the police consider necessary to ensure the safety and security of the victim or witnesses.

Police officers should immediately:

1. Submit completed form 11.1 for entry into the POR/CPIC. Any changes to conditions (varied or cancelled) are updated in the POR/CPIC;
2. Share the completed form 11.1 with the bail supervisor, if reporting conditions have been imposed; and
3. Forward the Report to Crown Counsel so that Crown counsel may address any attempt by the accused to change the bail conditions in court at or prior to the first appearance.

**Held for Bail Hearing before Justice of the Peace or Provincial Court Judge and Released on Conditions:**

In all cases where police determine there is a significant risk of violence, police should hold the accused for a bail or adjournment hearing, unless the investigator has a high degree of confidence that the risk factors can be effectively managed through UTA/PTA conditions appropriate victim safety planning, and in accordance with the Criminal Code, s. 497–499.

**Important notes regarding POLICE RELEASE CONDITIONS:**

- Prior to releasing an accused under an 11.1 Undertaking to Appear (UTA), police should always check for other bail conditions or UTAs that may have been imposed by criminal or family court. Police should explain to the accused the need to obey existing orders. When a breach relates to an existing order on a domestic violence case, police should not release the accused on an 11.1 UTA but rather hold the person for court.
- Police officer releases do not apply to offences that are punishable in excess of five years in jail.
- The wording of some conditions in form 11.1 may not provide adequate protection to victims. For example, case law indicates court issued "no-contact" orders offer victims greater protection than form 11.1 "non-communication" conditions.
- Amendments to a form 11.1 UTA must be done judicially.
- Police have no power to impose a weapons prohibition (distinct from a firearms prohibition). When a weapon (e.g., knife) is used or threatened, serious consideration is given to seeking a weapons prohibition through a bail hearing. A court may impose a prohibition order for firearms and other weapons. Police can seek such an order either under section 111 of the Criminal Code or through a bail hearing.

The Report to Crown Counsel should provide the evidence necessary to support a recommendation to the court that:

- The victim requires a higher measure of protection from the accused through the issuance of "no contact" orders rather than from "non-communication" conditions available in a form 11.1; and
- A condition prohibiting the accused from possessing firearms, cross-bows, knives, prohibited and restricted weapons, prohibited devices or ammunition and explosives, is necessary and appropriate in the circumstances.

If an accused is released on conditions, police should immediately provide corrections officials with relevant documentation (including risk analysis information). In cases when children are present, police should also notify the child welfare worker of the release and conditions.

**Request for court ordered detention**

Where police determine that there is a significant risk of violence, or concerns that the accused will not obey imposed release conditions, the accused is held for court and a detention order from a judge (or justice of the peace) is sought. Section 518(1)(d.2) of the Criminal Code requires a judge to consider any evidence submitted regarding the need to ensure the safety and security of a victim or witness.

More time might be required to conduct additional investigation or to gather further information to determine if it is necessary to detain the accused for the safety or protection of a victim, witness or the public. In this case, Crown counsel may apply to the court to adjourn the show cause hearing for up to three days according to section 516 of the Criminal Code. Police must clearly articulate the investigative steps already taken to obtain the necessary information to assess the safety concerns. They may also be required to explain the steps necessary to obtain the required information should the adjournment be granted.

Subsection 516(2) of the Criminal Code authorizes a justice who remands an accused to custody under subsection 516(1) or subsection 515(11) to order that the accused abstain from communicating directly or indirectly, with any victim, witness or other person identified in the order. The only exemption to this abstention must be in accordance with conditions specified in the order that the justice considers necessary.

## Residence

If as a result of a charge, the accused will be prevented by condition from returning to their previous residence, every effort should be made to confirm a residence prior to release. If residence cannot be confirmed prior to release, the bail supervisor should be provided with residence approval authority. If there is concern regarding risk, and residence cannot be confirmed prior to release, the accused is viewed as a risk to breach bail and/or to commit additional offences and should be held for a bail hearing.

## Reporting

Police should request Crown counsel to seek a condition requiring that the accused report to a bail supervisor.

### Victim Notification

If an accused is released from custody police are to notify the victim about the release and explain the conditions prior to the accused's release. When agreed practices have been established in the community, Crown counsel or designated personnel may inform the victim. A hard copy of the Undertaking to Appear (UTA) is to be provided to the victim as soon as possible. If the UTA/Promise to Appear (PTA) is cancelled, the victim must be notified.

Police should ensure that victim safety issues are addressed. The arresting officer advises the releasing officer of the telephone number and address where the victim is located.

### Safe Haven

If an arrest is not immediately possible, police identify a safe haven for the victim and any children present (for example, a transition house with support services). Transportation is provided or arranged, if required.

## Charge

### Decision to Prosecute

Police should advise the suspect and victim(s) that all domestic violence cases are treated as serious criminal matters, and that it is the responsibility of police to investigate and Crown counsel, not the victim, to decide whether criminal charges should proceed. When evidence indicates that an offence occurred, police should submit a Report to Crown Counsel recommending a charge even if there are no injuries to the victim and regardless of the victim's desire or willingness to lay charges and/or testify in a criminal prosecution. If a victim does not provide a written witness statement but there is still evidence to support a charge, a Report to Crown Counsel should still be completed. Follow-up is done at a later date to encourage the victim to provide a written statement.

All breaches of bail on a spousal violence case and/or related court orders require assessment, no matter how minor, and charges should always be considered when a breach threatens victim or witness safety. Police ensure all relevant information regarding the breach (including risk assessment information) is shared on a priority basis with bail supervisors/probation officers and appropriate contacts from child welfare.

All domestic violence cases are treated as serious criminal matters. While it is the police who investigate the matter, it is up to Crown counsel, not the victim(s), to decide whether criminal charges should proceed.

### Submitting Charges

Police submit all recommendations for charges as soon as possible and within 24 hours for warrant requests.

### Processing Suspect

All suspects are processed according to the Identification of Criminals Act (i.e., booking and fingerprinting).

Police should support Crown counsel's efforts to process charges as quickly as possible, especially when a warrant request is made.

### Recognizance

When evidence doesn't support charges, but a complainant reasonably fears for their safety or fears that the safety of their children might be in jeopardy, police should submit a Report to Crown Counsel recommending that an application be made for a recognizance according to section 810 of the Criminal Code.

Police should immediately inform the complainant that police must still complete a Report to Crown Counsel and are empowered to (and will) swear information on the complainant's behalf.

In recognizance applications (peace bonds) according to section 810, when the danger to the complainant is immediate but grounds for charges do not exist, a warrant is sought.

In cases when Crown counsel have sought a material witness warrant for a victim who failed to attend court to testify, police should make every effort to have the investigating officer who is familiar with the case execute the warrant.

### POLICE SUPERVISOR

Due to the complexity of domestic violence cases, and the risk to victim safety, a high degree of supervision is required. Police supervisors should review all domestic violence incidents regardless of whether an arrest was made and prior to disposition of the accused by remand or release.

The arresting officer decides whether a suspect is released. Supervisors ensure that the grounds on which this decision is made are clearly articulated, based on evidence and focused on risk.

When a charge is not recommended, the officer's decision (including rationale and evidence) are documented on the case file and affirmed by a supervisor. They keep in mind this policy as well as the operational policy of their department or detachment.

## Services to Victims

Police provide necessary assistance to victims of violence and are responsive to their needs. When requested, police stand by to keep the peace in case either party wishes to return to the residence to collect personal effects.

### Referral

Referring victims to victim services is crucial. As soon as possible, police should provide a referral to victim services and advise the victims that a victim service worker will contact them.[15] Police should also inform victims of other community support services that are available for victims and their children.

Police inform victims of, and refer cases to, community-based victim service programs where they exist. If assistance is required outside of regular office hours, police-based victim services may be available to provide immediate crisis support before referring the case to the community-based program. Transition houses, which operate 24/7, are also an option for immediate crisis support.

15. Referrals are made in accordance with the *Ministry of Public Safety and Solicitor General's Referral Policy for Victims of Power-Based Crimes*.

Where no community-based victim services are available, cases should be referred to police-based victim services for support and assistance. Where no community or police-based victim services are available locally, police should provide victims with assistance directly and refer the individual to VictimLink BC at 1 800 563-0808 for crisis support.

Police proactively assist victims and their children by arranging safe transportation to a transition house, safe home or other safe shelter. Where resources exist, crisis teams involving social services professionals are relied upon for support.

Police should inform victims that a victim support worker or advocate, if available and appropriate, may accompany the victim to their police interview, if the victim wishes. If victims will not testify unless they are accompanied to court by a police officer because the accused poses a danger to them, arrangements are made to support the victim.

Violence Against Women In Relationships POLICY

VictimLink BC crisis support helpline: 1 800 563-0808

## Services to Victims with Special Needs

The police may be the only chance for effective intervention in cases when the couple is elderly and abuse has been long term, or when cultural, religious, community or family values, sexual orientation or disability (physical or mental), make it difficult or impossible to seek assistance to stop the violence. In such situations, respectful and dignified treatment of the victims and an understanding of the dynamics of domestic violence are critical. Police must be sensitive and accommodating when dealing with victims/witnesses who have special needs due to isolation, mobility restrictions, and language or communication abilities. It might be necessary to alter investigative procedures for victims with special needs.

Consideration should be given to allowing support persons for victims/witnesses to be present during interviews, regardless of whether an interpreter is present. It must not be assumed that an immigrant victim who can speak some English is able to fully understand the language and/or the context of the justice and child welfare systems in B.C.

The accused, young children, family members of the victim or accused should never be used as interpreters. It is preferable to utilize an individual who is unrelated to the accused or victim wherever possible. Names of interpreters used (and their relationship to the parties, if any), are to be recorded on the file.

Police should clearly indicate on the Report to Crown Counsel witness pages that the victim has special needs because of mental or physical disability, language barriers, religion or cultural values. If no victim or support service is available to meet the victim's needs, this information is to be communicated to Crown counsel.

## Monitoring

Because domestic violence cases are complex and often involve dynamic factors, the risks posed to victims may change when new or unforeseen circumstances develop. Consequently, a reassessment of risk might be required in conjunction with communication with other involved agencies (e.g., child welfare worker, corrections staff) to ensure the continued safety of victims.



Violence Against Women In Relationships POLICY

Police should:

- Monitor the suspect to ensure compliance with imposed conditions;
- Check with the victim (or with victim services) on the status of safety planning; and
- Ensure that any breach of release conditions results in a review of the risks present in the case, and a reconsideration of what measures, if any, are necessary to protect the victim.

Complete VAWIR policy available at https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/info-resources/vawir.pdf

## Appendix G – Summary Table of Studies (2008 -2019)

| Author and year | Title | Method | Purpose | Findings |
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| Ahmad et al. (2009) | Why doesn't she seek help for partner abuse?'' An exploratory study with South Asian immigrant women. | A qualitative study of 3 focus groups of 22 women. It was conducted in the Hindi language with South Asian immigrant women in Toronto. Mean age of 46 years (range 26 -68 years). | To explore reasons for delay in help seeking from professionals by South Asian immigrant women experiencing IPV. | • 3 major themes: reasons for delayed help-seeking, turning points and talking to professionals.<br>• Help-seeking delayed due to: social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration and limited knowledge about available resources and myths about IPV.<br>• Help sought only after experiencing serious mental and physical health problems. |
| Ahmad et al. (2017) | South Asian Immigrant Men and Women and Conceptions of Partner Violence. | Employed participatory concept mapping in three phases. | To explore the conceptual variations in defining intimate partner violence (IPV) by ethnicity among South Asian (SA) immigrant men and women. | Both SA men and women had:<br>• similar views about sexual abuse and victim resistance<br>• an expanded understanding of the concept of controlling behaviors<br>Yet:<br>• SA women viewed some aggressive behaviors and acts as cultural and<br>• identified some IPV acts as private or public |

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| Ahmad et. (2013) | Resilience and Resources Among South Asian Immigrant Women as Survivors of Partner Violence. | A qualitative study with in-depth interviews. | To explore resilience among South Asian (SA) immigrant women who were survivors of intimate partner violence (IPV). | Resilience influenced by:<br>• Individual cognitive abilities, social support, and professional assistance despite their challenges as immigrants.<br>• SA immigrant women IPV survivors sought multiple resources at all levels,<br>• Highlighted the significance of socio-ecological approaches in programs and policies along with inter-sectoral coordination to assist resilience. |
| Ahmad-Stout et al.(2018) | Experiences of Intimate Partner Violence: Findings From Interviews With South Asian Women in the United States. | 11 South Asian women were recruited from three domestic violence agencies in the United States and interviewed to examine their experiences with intimate partner violence (IPV). | To examine the experiences of IPV of SA women. | • The importance of families of origin and in-laws in the process of leaving the relationship.<br>• Children cited as a source of strength for the women.<br>• Provide insights to the process of healing and recovery after leaving an IPV relationship. |
| Amanor-Boadu et al. (2012) | Immigrant and Non-immigrant Women: Factors That Predict Leaving an Abusive Relationship. | Quantitative study using logistic regression to test components as predictors of the decision to separate from an abusive partner, between immigrant (n = 497) and non-immigrant (n = 808) women. | To examine the similarities and differences between immigrant and non-immigrant groups in regard to the risks and barriers that predict leaving an abusive relationship. | • Immigrant women reported higher levels of perceived risks/barriers to leaving<br>• provided some support for the use of a holistic risk assessment in understanding women's decisions to leave<br>• demonstrated that immigrant and non-immigrant women have similarities and differences in the factors that predict leaving<br>• indicated both clinical and policy implications |

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| Anitha (2008) | Neither safety nor justice: the UK government response to domestic violence against immigrant women. | A qualitative study conducted in 2007 of interviews with 30 South Asian women with no recourse to public funds due to their status as recent marriage migrants. | To examine the extent to which government's policy towards immigrant women experiencing domestic violence responds to their needs. | • Legislation effectiveness found to be severely hampered by a lack of consideration of the multiple dimensions confronting recent marriage migrants. |
| Anitha (2010) | No Recourse, No Support: State Policy and Practice towards South Asian Women Facing Domestic Violence in the UK. | A qualitative interviews with 30 South Asian women who were barred from receiving public funds due to their status as recent marriage migrants. | To examine the extent to which government policy and practice meet the needs of women with insecure immigration status who are experiencing domestic violence. | • The importance of accessibility to financial and safety considerations for SA IPV survivors<br>• Access to housing and financial support to rebuild lives<br>• Creating short-term and long-terms solutions. |
| Belur (2008) | Is policing domestic violence institutionally racist? A case study of south Asian Women. | Qualitative study involving observational research in 2 police forces. 12 semi-structured, open-ended interviews were conducted with Asian women and their views on policing. | To examine the relationship between police services offered to Asian women as victims of domestic violence and institutional racism. | • The identification and understanding of policing IPV incidents in the Asian community and institutionally racist practices.<br>• Potential for more focus and stronger impetus for introducing reforms and changes in police policy, practice, and training. |

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| Bhandari (2018) | South Asian women's coping strategies in the face of domestic violence in the United States. | A qualitative study involving in-depth telephone interviews with a convenience sample of 20 South Asian women experiencing IPV in the United States. | To examine the coping strategies of South Asian women experiencing IPV support, and barriers of language and immigration. | • Emotion-focused coping strategies included spirituality and/or religion and the role of children.<br>• Problem-focused coping strategies included informal and formal support and strategies of resisting, pacifying, and safety planning. |
| Bhuyan (2008) | The Production of the "Battered Immigrant" in Public Policy and Domestic Violence Advocacy. | An ethnographic study of the impact of economic, political and economic processes of domestic advocacy with immigrants. | To examine how the difference in signification has direct social and political consequences of who may access the benefits and protection offered to victims of IPV in the United States. | • Recognition of the dangers facing IPV immigrants<br>• The multiple steps to accessing legalities and the perception of productive immigrants<br>• The promise of freedom and being a legal resident<br>• Problems confronting IPV immigrants ineligible for state health and social benefits<br>• The work of IPV advocates in increasing the safety of the immigrants |
| Hyman et al. (2009) | Help-seeking behavior for ipv among racial minority women in Canada. | Qualitative study of a national Canadian, cross-sectional, telephone survey of help-seeking variables. | To determine whether a woman's racial minority status was a significant predictor of help-seeking for IPV after controlling for other factors associated with help-seeking. | • Rates of disclosure and reporting to police were similar for racial minority and white women.<br>• Racial minority women were significantly less likely to use social services.<br>• Racial minority status was not found to be a significant predictor of help-seeking after adjusting for age, marital status, household income, number of young children at home, immigration status, household language, and severity of IPV. |

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| Jordan & Bhandari (2016) | Lived Experiences of South Asian Women Facing Domestic Violence in the United States. | A qualitative study of in-depth telephonic interviews conducted all across the United States. | To understand the lived experiences of IPV among a convenience sample of 20 South Asian women. | • 4 major categories of abuse: (a) types of abuse; (b) abuse involving children; (c) family involvement in abuse; and (d) formal and informal support.<br>• Understanding barriers to seeking formal services including police assistance<br>• Need for increased access to medical and emergency services<br>• Understanding of formal service providers of the barriers and hesitancy to seek help<br>• Increasing internet access to resources and information. |
| Kanagaratnam et al. (2012) | Burden of Womanhood: Tamil Women's Perceptions of Coping with Intimate Partner Violence. | A qualitative study of 63 women from the Tamil community in Toronto representing different generations and experiences of IPV were interviewed in focus group settings about their views of coping with IPV. | To understand the perceptions of coping with IPV from the perspective of a specific immigrant group of women. | • Participant views were deeply entrenched in their sociocultural context and influenced by the gender-role expectations of their community.<br>• Displayed a clear preference for more passive ways of coping instead of proactive ones. |
| Lipsky et al. (2009). | Racial and ethnic disparities in police-reported IPV & risk of hospitalization among women. | A cohort study of adult male-to-female IPV police records of non-Hispanic Black, Hispanic, and non-Hispanic White women residing in a south central US city with regional hospital discharge data. | To examine racial and ethnic disparities in police-reported IPV and hospitalization rates and rate ratios among women with police-reported IPV relative to those without such reports. | • Police-reported IPV rates were 2–3 times higher among Black and Hispanic women compared with White women.<br>• Hospitalization rates were higher among Black and White victims and lower among Hispanic victims than their counterparts. |

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| Mason et al. (2008) | "Violence Is an International Language" Tamil Women's Perceptions of Intimate Partner Violence. | A qualitative study of focus group interviews conducted with women representing different ages and stages of life. | To examine the ways in which Sri Lankan Tamil women in Toronto understand, define, and experience IPV. | • Definitions of IPV were not culturally specific.<br>• Tamil women defined IPV broadly and recognized different forms of coercive control.<br>• Psychologically abusive behaviors held particular meanings for the community. |
| Messing et al. (2013) | Culturally Competent Intimate Partner Violence Risk Assessment: Adapting the Danger Assessment for Immigrant Women. | A longitudinal risk assessment study of 148 immigrant women. The 20 original DA items and an additional 12 risk items were tested using relative risk ratios for their association with any or severe IPV at a follow-up interview. | To modify the Danger Assessment (DA), a risk assessment instrument aimed at identifying victims of IPV who are at risk for lethal violence by an intimate or ex-intimate partner, for immigrant women. | • Supported a revised Danger Assessment for Immigrant Women (DA-I) consisting of 26 items. The DA-I predicts any and severe IPV at a nine-month follow-up significantly better than the original DA and women's predictions of risk.<br>• The DA-I is a culturally competent risk assessment that can be used to assess the risk of re-assault and severe IPV to assist immigrant women with safety planning. |

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| Messing et al. (2014) | Factors Related to Sexual Abuse and Forced Sex in a Sample of Women Experiencing Police-involved Intimate Partner Violence. | A quantitative study using multinomial logistic regression to examine the factors related to sexual abuse and forced sex, controlling for victim and relationship characteristics. | To examine the prevalence and factors associated with IPSV among a sample of women recruited at the scene of police-involved intimate partner violence incidents (N= 432). | • 43.98 percent of participants reported experiencing IPSV;<br>• Women sexually abused or forced into sexual intercourse were significantly more likely to experience strangulation, feelings of shame, and post- traumatic stress disorder symptoms.<br>• Women whose partners had forced sex:<br>  ○ more likely had a child in common with their abusive partner;<br>  ○ Had partner who was sexually jealous, had threatened to kill them, had stalked or harassed them, or caused them to have a miscarriage due to abuse.<br>• To better inform practitioners about prevalence and nature of IPSV and the associated risk factors, and assist in routine screening and intervention. |
| Sabri et al. (2016) | Gender Differences in Intimate Partner Homicides Among Ethnic Sub-Groups of Asians. | Data from newspapers and femicide reports by different state coalitions on 125 intimate partner killings occurring between 2000 and 2005 were analyzed. | To explore differences in intimate partner homicides (IPHs) among Asian Americans. | • Men were the perpetrators in nearly 9 out of 10 cases of Asian IPHs.<br>• Gender differences were found in ages of victims and perpetrators, types of relationship between partners, and methods of killing.<br>• Most homicides occurred among Southeast Asians<br>• East Asians had the highest within-group suicides<br>• Need for culturally competent risk assessment and intervention strategies to address IPHs for at-risk communities. |

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| Sabri et al. (2018) | Multilevel Risk and Protective Factors for Intimate Partner Violence Among African, Asian, and Latina Immigrant and Refugee Women: Perceptions of Effective Safety Planning Interventions. | A qualitative study of 83 in-depth interviews were conducted with adult immigrant and refugee survivors of IPV, who identified as Asian (n = 30), Latina (n = 30), and African (n = 23). 9 focus groups and 5 key informant interviews with practitioners (n = 62) who serve immigrant and refugee survivors of IPV. | To identify survivors and practitioners' perceptions of (a) common and culturally specific risk and protective factors for IPV and IPH for immigrant and refugee women and (b) areas of safety planning interventions for survivors who are at risk for severe or lethal violence by an intimate partner. | • Multilevel risk and protective factors for IPV/IPH at the societal level, relationship level and individual level.<br>• Inform the development of culturally responsive risk assessment and safety planning interventions across legal, social service, and healthcare settings. |
| Sabri, et al. (2018) | Risk and Protective Factors of Intimate Partner Violence Among South Asian Immigrant Women and Perceived Need for Services. 2018 | A qualitative study of in-depth interviews and a focus group with 16 South Asian immigrant survivors from New York; Maryland; Virginia; and Washington, DC. Participants were 1st-generation and 2nd-generation immigrants born in India (n 4), Bangladesh (n 4), Pakistan (n 5), the United States (n 2), and Sri Lanka (n 1). | To examine risk and protective factors of IPV among South Asian immigrant survivors of IPV and identify their perceived need for services. | • Factors affecting IPV: normalization of culture, expectations based on gender roles, family honor, arranged marriages, behaviours of abusive partners, and the fear of losing children and living on their own<br>• Protective factors: support of family and friends, religion, being aware of safety strategies, being educated and empowered<br>• Need to educate and increase efforts for culturally responsive services<br>• Consideration for culturally specific risk and protective factors to inform and create culturally responsive IPV prevention and intervention strategies. |

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| Satyen et al. (2018) | Intimate Partner Violence and Help-Seeking Behavior among Migrant Women in Australia. 2018 | A qualitative study of 130 immigrant women from Asia, Europe, South America, North America and Africa aged between 19 and 65 years (M= 38.15years) using surveys. | To determine the extent to which Australian immigrant women experience IPV and understand the factors influencing help-seeking behavior. | • Over 50% experienced at least one form of IPV<br>• Most women indicated that they needed help<br>• Many refrained from help seeking<br>• Barriers to help seeking. |
| Soglin et al. (2019) | A Validated Screening Instrument for Identifying Intimate Partner Violence in South Asian Immigrant Women. | Tool validation using the Index of Spouse Abuse (ISA). 116 South Asian immigrant women participated from a medical clinic and two community centers in Chicago, IL. | To validate the South Asian Violence Screen (SAVS) - a 14-item screening tool for IPV based on demographic and cultural issues of South Asian immigrant women in the United States. | • The study demonstrated the SAVS as an effective and efficient screening tool for the South Asian immigrant population in Chicago. |
| Soglin et al. (2019) | Assessing Intimate Partner Violence in South Asian Women Using the Index of Spouse Abuse. 2019 | A quantitative study. | To determine the validity of the Index of Spouse Abuse (ISA) as an IPV screening tool and to determine the prevalence of IPV among a SA immigrant people. | • 31% of women screened positive on one or both ISA scales.<br>• The ISA-P and ISA-NP items as highly reliable<br>• ISA is a valid and reliable IPV screening tool for the SA immigrant population. |

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| Tam et al. (2015) | Racial Minority Women and Criminal Justice Responses to Domestic Violence. | A qualitative study of the struggles of 14 racial minority women from three Canadian cities and their experiences with the police and criminal court's response to their partner's acts of domestic violence. | To examine racialized minority women's experiences with Canadian specialized criminal justice responses to IPV. | • Responses of specialized criminal justice responses to the needs of women and protect them from further violence.<br>• Factors that facilitate or deter women from approaching the criminal justice system for help.<br>• Implications of women's narratives for criminal justice responses to IPV. |
| Thapa-Oli et al. (2009) | A Preliminary Study of Intimate Partner Violence Among Nepali Women in the United States. | A qualitative study of IPV among Nepali women in the United States. | To explore the prevalence of and vulnerabilities to IPV among Nepali immigrant women in the New York metropolitan area. | • 75.6% of women experienced verbal abuse by current partners<br>• 62.2% had to seek permission from their partners to go to their friends' or relatives' houses. |
| Tonsing (2014) | Conceptualizing Partner Abuse Among South Asian Women in Hong Kong. | A qualitative study with 14 interviews with South Asian women of IPV. | To explore the perception and experiences of domestic violence by an intimate partner of South Asian women in Hong Kong. | • IPV as a concern for South Asian women.<br>• The need for culturally appropriate IPV services and public education for the community |

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| Tonsing (2015) | Complexity of domestic violence in a South Asian context in Hong Kong: cultural and structural impact. | Quantitative study of South Asian women's experience of IPV in Hong Kong through in-depth interviews with 14 South Asian women and 6 helping professionals from 4 social service agencies. | To engage with migrant South Asian women's understanding and experience of IPV. | • Nature and context was a barrier to help seeking.<br>• Importance of understanding the influence of cultural and structural conditions<br>• Vulnerabilities of abuse increase the difficulties and complexities faced by women<br>• Structural impact to distress and vulnerability<br>• The need for inclusivity of service provision vulnerable and marginalized women. |
| Williams & Mohammed (2013) | Racism and Health II: A Needed Research Agenda for Effective Interventions. | An empirical review. | To review empirical evidence for ways in which interventions can reduce the multiple dimensions of racism to improve health and reduce disparities in health. | Individual and community health can be improved by:<br>• Policies and procedures to reduce institutional racism<br>• Interventions that reduce societal and individual cultural racism<br>• enhancing health capacities of medical care,<br>• focusing on social factors causing and sustaining risk behaviors, and<br>• Empowering to lives and health. |

## Appendix H – Publication/Presentations during Candidature

**Publications - Abstract**

- **Kaur, H.** Cross, W., Plummer, V. (2017). Improving Health and Safety for Immigrant South-Asian women Survivors of Intimate Partner Violence, *Journal of Qualitative Health Research*, 74.

**Conferences/Oral presentations**

- **Kaur, H.** (2017). Improving Health and Safety for Immigrant South-Asian women Survivors of Intimate Partner Violence. 23rd International Qualitative Health Research Conference, October 18, 2017. Quebec, Canada.
- **Kaur, H.** (2016). Are We Safe? Preliminary Results of Study. Valuing Diversity, Provincial Conference, BC Society of Transition Houses, October 28, 2016. Richmond, BC, Canada
- Usma, M. S., & **Kaur, H.** (2015). Enhancing Online Help Seeking (Poster) Australia Stop Domestic Violence Conference, December 7-9, 2015. Canberra, Australia.**Kaur, H.** (2015). Connecting the Dots: Research Study & Health Care Implications of Forced Marriage. Panel Presentation, Provincial Legal Advocates Conference, October 8, 2015. Richmond, BC, Canada.