

Commissioned by Manchester, Salford and Trafford Health Action Zone

ATTEMPTED SUICIDE AND SELF-HARM (SOUTH ASIAN WOMEN)

Project Report
March 2001

Khatidja Chantler
Erica Burman
Janet Batsleer
Colsom Bashir



health
through *Action*

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Khatidja Chantler
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EXECUTIVE SUMMARY

This research study on service responses to attempted suicide and self-harm in relation to South Asian¹ women was commissioned by the Manchester, Salford and Trafford Health Action Zone (M, S & T HAZ), over a ten month period from June 2000 to March 2001. It was conducted by Khatidja Chantler (Independent Researcher) in partnership with the Women's Studies Research Centre of the Manchester Metropolitan University (MMU). The staff from MMU were Professor Erica Burman (Department of Psychology and Speech Pathology) and Janet Batsleer (Department of Applied Community Studies). Partnership arrangements were also negotiated with the Central Manchester Primary Care Trust's Mental Health Needs Assessment/Commissioning Project for the community perspectives strand of this study. The community perspectives part of the study was conducted by Colsom Bashir.

The study was set in the overall national policy context of reducing suicide and undetermined injury by at least a further sixth by 2010 (Our Healthier Nation) as well as the National Service Framework for Mental Health, which makes the prevention of suicide one of its key priorities. At a more local level, within M, S & T HAZ's mental health action plan, the target is to reduce suicide by 5% for South Asian women by 2002.

Measuring rates of suicide is complex, but the current measurement is that there are just over 4,000 deaths from suicide a year nationally (Kelly and Bunting 1998, Chief medical officer 1998). Whereas national figures break down the number of suicides by age and gender, they do not identify ethnicity. However, the research carried out by Soni Raleigh (1996) indicates that suicide is high in young Asian women compared to other ethnic groups. Studies by Merrill et al (1986, 1990) indicate that risks are high in UK born Asian women. As Soni Raleigh also notes, the high rates of suicide and attempted suicide is consistent in the international literature (e.g. Flisher and Parry 1994). All the available information, including qualitative studies such as this, strongly indicate the need for the provision of sensitive and relevant services to South Asian women attempting suicide and/or self-harm.

The importance of wider contextual issues, particularly racism and sexism are especially relevant for this study as well as how these intersect with mental health policy and practice. Evidence from a number of sources illustrates unequal access to and treatment of Black² people within the mental health system (e.g. Ahmad, 1992; Fernando, 1991; Littlewood & Lipsedge, 1982). However, the specific experiences of Black women are largely excluded, both in the literature on 'race' and mental health and women and mental health (Aitken

¹ The term South Asian refers to people whose family or cultural heritage originates from India, Pakistan, Bangladesh or Sri Lanka.

² The term Black is used as a collective term to refer to visible minorities e.g. people of African, Caribbean and Asian descent who experience racism on the basis of skin colour and culture.

1996; Burman et al, 1998). Hence the needs of black women remain hidden. Clearly, mental health policy and practice at a local level (M,S & T HAZ) is part of this wider context.

Whereas this study helps to make visible previously invisible experiences, and to engage with the specificity of South Asian women's experiences of distress and their experiences of helping agencies, it is crucial that this does not lead to the further pathologising of South Asian women and communities. In terms of the specific concerns of this report, it is important that the problem is not seen to reside in, or with, South Asian people or communities, but in the contexts and services whose responsibility it is to support them. Hence, key to our study has been our concern that this research does not itself perpetuate stereotypical constructions of South Asian women as passive victims, or of assumptions of South Asian communities as homogeneous along lines of gender, class and other oppressions.

Objectives of the Research

The primary purpose of the study was to conduct a qualitative study of suicide and self harm services in relation to South Asian women in the HAZ area in order:

- To compile a service map of potential sources of help
- To identify the current level and appropriateness of services being offered to South Asian women who self harm and/or are suicidal
- To increase understanding of the specificities of the factors contributing to the distress of South Asian women
- To identify examples of good practice
- To identify gaps in service provision to this service user group
- To make recommendations to improve self-harm/suicide services to South Asian women

The research study had several strands to it and aimed to generate a range of perspectives of attempted suicide and self-harm by interviewing the following:

- Senior managers in health, social services and the voluntary sector
- Workers/Practitioners in the mental health field (either directly or indirectly) from statutory, voluntary and community groups
- South Asian women who had attempted suicide and / or self-harm
- South Asian community perspectives – women's groups

The findings and conclusions of this report are based on the analysis of individual interviews and group discussions with: 8 senior managers, 18 worker discussions, 7 survivors of attempted suicide and self-harm and 4 South Asian women's groups. The analysis of each of these strands are summarised below, followed by the overall conclusions and recommendations.

A. SENIOR MANAGER PERSPECTIVES

The Impact of the Contract Culture on the Voluntary Sector

The impact of the contract culture emerged as an important issue in the senior manager interviews, specifically the relationship between commissioners and providers where each sees the other as responsible for ensuring appropriate services for South Asian women in distress. The threats to the autonomy of the voluntary sector was also discussed, especially its fragmentation through competition. The traditional strengths of the voluntary sector, particularly campaigning work and radical practice are also jeopardised with tightly controlled contracts replicating funders' priorities both in terms of concentrating on 'medical' categorisation of service users and the consequent emphasis on service delivery.

Partnership Working

Turning to partnership working, the evidence demonstrates partnership arrangements are more firmly secured with South Asian community groups compared with South Asian service users or carers. However, within community consultations, the current focus appears to be on consulting with the more dominant rather than the more vulnerable or marginalised. It is strongly argued that consultations should be targeted at listening to the voices of South Asian women in recognition of the diversity within communities based on power relations. Hence women-only spaces are important as is the central role of South Asian women's refuges – a hitherto unrecognised mental health resource.

The 'whiteness' and 'maleness' of service user groups as the loudest voice and the consequent silencing of women's voices, especially South Asian women needs to be rectified. Several measures are either in place or coming on line to widen the participation of service users and carers, for example service user or carer development worker posts. However, no evidence was offered as to how this would include South Asian people. It also needs to be recognised that 'champions' such as these as well others within services (e.g. Black workers), are themselves often marginalised and therefore the potential for change is limited if it is seen as being solely their responsibility. The need for 'embedded structures' is therefore crucial. Lessons of tokenism and marginalisation, particularly from the experiences of Black workers are important to learn from, if the service user and carer groups are not to become exploited and appropriated in the same way.

Enhancing Senior Managers' Understandings of Suicide and Self-harm in relation to South Asian women

Senior managers' understanding of the issues contributing to South Asian women attempting suicide and self-harm needs to be enhanced in three key ways. It is argued, firstly, that the

focus on 'cultural' issues helps to camouflage and sanitise the brutality of women's lived experiences and secondly, in this context culture – or rather 'Asian culture' could be seen as deficient and problematic. Thirdly, the focus on culture, treated as a marker of 'race' becomes privileged at the expense of gender and the interconnections between 'race'/gender/ class etc. It is therefore urgent that cultural understandings are located within the wider and intersecting contexts of racism, sexism, and class – as is amply illustrated by the survivors' accounts.

Current Configurations of Mental Health Services

There are three principal ways in which mental health services are offered to South Asian women. These are through: 'universal' or generic, mainstream services, specialist South Asian mental health services and through South Asian community groups.

The evidence clearly illustrates that universal provision has not taken into consideration the needs of South Asian women. There appears to be a reluctance to focus specifically on South Asian women, either because of the small percentage of South Asian people in certain localities or because it was felt that mental health services needed improving for everyone – not just South Asian women. However, the universalist framework operates from a 'colour blind' perspective and the exclusion of South Asian women in the consideration of mental health services as evidenced in the report, and the need to justify spending resources on this group requires challenging. Central to this, is the need for a re-conceptualising of the issues with an understanding of the intersections between 'race', gender, and class. This new frame of reference could provide opportunities to adopt a more radical approach by starting with the needs of South Asian women, with ripple effects into improving services for other women too (e.g. single sex accommodation, audio/visual information about services, choice of male/female worker, home-based or centre-based services and appropriate child support).

Although specialist South Asian mental health projects are to be encouraged, in the context of suicide and self-harm it is vital that they are woman-centred and that the workers have the required competencies to work effectively with issues of suicide and self-harm. The relationship between such services and funders currently indicates that they are a tokenistic response. Whilst on the whole senior managers recognise that their own services need to be more sensitive and relevant, little evidence was offered as to how this was to happen. In relation to suicide and self-harm, the picture emerging from workers from South Asian mental health projects was that they would refer back to mainstream services and co-work where feasible. Similarly, the funding of generic South Asian community groups whilst providing "low intensity" support do not offer support in times of crises and again women in distress would be referred back to mainstream agencies. Hence the circularity of this process cannot be ignored and it is essential that mainstream services act to ensure that their services are more accessible.

Recruitment and Training Issues

Two key strategies were suggested by senior managers for improving mainstream services: increasing the number of South Asian woman workers, and staff and management development. Apart from the issues of tokenism and marginalisation already discussed, consideration also has to be given to the conceptual frameworks and theoretical models that are used in service delivery. If these remain unchanged, then the question of what difference a worker of a different colour or culture, or gender makes has to be asked. The assumption that theoretical models are politics-free and therefore universally applicable is clearly questionable. In respect of training, one or two day workshops around 'race' are not adequate as the key intervention to deal with race equality. Training is unlikely to work unless it is part of a proactive wider strategy to counter organisational and institutional structures which discriminate and oppress marginalised groups. Suicide and self-harm poses complex issues for training that call for practices that connect anti-racist and gender-sensitive understandings as well as clinical management of distress and abuse.

B. WORKER DISCUSSIONS

Workers' Understandings of Attempted Suicide and Self-harm

There appeared to be a common understanding amongst workers of what self-harm behaviour was and the meanings that were ascribed to this. Significantly, no particular methods were perceived to be specific to South Asian women. There was also a shared understanding that self-harm was a way of dealing with difficult and painful emotional issues by diverting attention away from the emotional to the physical to provide a temporary sense of relief and well-being. Intention to kill oneself was seen as a major difference between self-harm and attempted suicide. However, the relationship between suicide and self-harm is complex. Self-harm is both a protective factor against suicide (Spandler, 1996) and a potentially high risk factor in suicide (Hawton & Fagg, 1988). It was disappointing to note that despite some good practice around attempted suicide and self-harm, there is still the perception that people who self-harm or with repeat suicide attempts are attention seeking and a drain on resources as the injuries were self-inflicted.

'Culture' Clash

Many workers (white and black) talked about the problems of living in two cultures and the difficulties encountered in negotiating the differences. They saw this to be a key factor in South Asian women self-harming and attempting suicide. Significantly this was not mentioned by any of the survivors. The 'culture clash' analysis has several drawbacks. First, cultures are seen as essentialised, fixed and rigid rather than as dynamic and evolving. Second, implicit within this is the notion that it is only 'Asian' culture that is affected by the difference, so

that examples of the way in which aspects of Asian culture impact on the rest of society are overlooked and minimised. Third, and probably most important, what the 'culture clash' analysis does is to de-contextualise and to mask, ignore and perpetuate unequal power relations and to intervene in ways which make services inaccessible and insensitive to those whom they may be trying to reach. More specifically, this approach fails to engage with or to acknowledge issues such as sexual abuse, domestic violence, racism, immigration, patriarchy, forced marriages, and poverty. These are systemic and structural, and are very clearly articulated in the survivors' accounts.

Contextualising Services

In comparing the experiences of distress of white women and South Asian women, it needs to be understood that even where factors are in common with white women (e.g. aspects of domestic violence and sexual abuse), access to services for Asian women is far more difficult. Coupled with racism, isolation is much more acute with correspondingly fewer options to turn to.

It is therefore vital both for the understanding of South Asian women's distress and in making services more sensitive, that wider social issues are addressed – both in the configuration of services and in the training and perspectives of workers in the field.

Working Practices: Universality, Gender 'Neutrality' and 'Matching'

Three key approaches were shown to influence work practice in relation to South Asian women and mental distress. These are the 'race neutral' approach, the 'gender neutral' approach and 'matching'. The 'race neutral' approach is based on the idea of universality, that the same service is suitable for all, as discussed in the senior manager perspectives.

'Gender Neutrality'

The analysis of the 'gender neutral' approach in this study highlighted in particular the privileging of 'race' over gender. 'Race' anxiety, fears around 'political correctness' and the reluctance to challenge what are assumed to be cultural practices, all reify culture, and hence unequal power relations based on gender can be seen as acceptable (i.e. as part of the culture) within South Asian communities. The stereotype of the submissive and docile South Asian woman combined with the view that the oppression of women in South Asian communities is acceptable can lead to risky assessments which not only fail to protect South Asian women, but serve to perpetuate systems of oppression based on both racism and sexism. It is not being suggested here that gender should privilege issues of culture, but rather that the dynamics

of the two are recognised and worked with. This is not to deny the importance of cultural understandings, but to emphasise the importance of, and an alertness to, issues of power and oppression both within and outside of South Asian communities.

'Matching'

A further response to the call for culturally sensitive services has been to 'match' service users with practitioners from the same ethnic/cultural background. Given the plethora of variables between any two people, matching is a difficult concept to put into practice. Questions such as which variables are to be matched, what gets included and what is omitted and whose choice this is, are often overlooked. Within this, it is acknowledged that some workers may refer on because they genuinely believe that South Asian organisations (or workers) will be better equipped to meet the needs of South Asian women, and that workers who are not of a South Asian background may feel de-skilled in working with this group. However, it is urgent that white workers develop their knowledge and skills to enable them to work inter-culturally. It is equally urgent that workers in South Asian organisations are helped to develop the competencies required to work in this field, and that all practitioners are provided with adequate support and clinical supervision.

An important finding to emerge from this study is that gaps in service provision are created by a circular referral process. Statutory agencies refer South Asian women service users to some South Asian organisations who do not feel equipped to deal with issues of suicide and self-harm and thus refer them back to the statutory sector. Hence the needs of vulnerable South Asian women are clearly not being met by this process – either by the statutory sector or by (some) South Asian voluntary sector groups.

In relation to South Asian groups offering services in the mental health field, it is vital that all workers (including commissioners and providers) are aware of the differences in the value base or politics of the South Asian organisations they refer on to, or purchase services from, as these differences have serious consequences for the appropriateness of services to South Asian women. However, some very positive, powerful and supportive South Asian services and interventions were identified. They are being made by gender-specific services who are also operating from an anti-racist stance and are able to 'hold' and take appropriate risks around the complex work of attempted suicide and self-harm as it relates to South Asian women.

Supporting Workers

Given the complexity of work in this area and the wide range of powerful feelings that are evoked both by issues of attempted suicide and self-harm and issues of 'race' and culture, it is

essential that workers' (including link workers and interpreters) support needs are attended to and that safe practice is developed and sustained. Central to effective clinical supervision is the need to separate management tasks from the process of working with individual service users.

C. SURVIVOR ACCOUNTS

Systemic Issues, Attempted Suicide and Self-harm

Within this study, a range of inter linking factors, mainly systemic, were mentioned by South Asian women as contributing to their suicide attempts and self-harming. These were: sexual and physical abuse, domestic violence, immigration issues, forced marriages, racism, and issues of loss and bereavement. Issues that were closely allied and generated a lot of stress included poverty and homelessness.

The age range of survivors interviewed was from 17 years to 30 years. The most common method used for suicide attempts was through overdosing although other methods were also used: hanging and slashing of wrists. Those who self-harmed cut themselves, used burning, drank substances such as bleach or head lice shampoo, or misused substances including food, alcohol and illegal drugs. Significantly, three of the survivors either attempted suicide or started self-harming in their early teens and five of the survivors had attempted suicide more than once.

Domestic Violence and Attempted Suicide/Self-harm

A key theme clearly emerging from the survivor accounts are the links between domestic violence and attempted suicide and self-harm, as all but one of the survivors interviewed had experienced domestic violence. Whereas the generalities of domestic violence and commonalities with white women's experiences are important, the specificities of South Asian women's experiences of domestic violence also need to be attended to. Hence considerations and understandings of domestic violence and distress also need to be located within the context of housing policy, racial harassment, immigration, as well as cultural concepts such as honour and shame.

³ Underlying the one year rule is the assumption that people who come as an overseas spouse to somebody who is permanently resident in this country are coming primarily in order to settle here for immigration purposes rather than marriage purposes. Hence the assumption is that such marriages are 'bogus' until proven otherwise. The test that has been set to 'prove' the marriage is genuine is for the marriage to continue with both partners living together for a year. If within the year, the marriage does not work, foreign nationals would be deported, unless there are compassionate grounds.

Lack of Safety

In terms of specificities of experience, the smallness of South Asian community networks makes it very easy to locate South Asian women who have escaped violent relationships and thus speed of response in housing matters is crucial. Survivor accounts also highlight how many South Asian women feel safer in a different town or city from that of their abusive partner/family. However, there are also emotional costs, as in so doing, the woman may well come to a place where she has no connections, friends or family, thus generating further need for supportive service provision. Moreover, in the search for 'invisibility' within South Asian communities, survivors may choose to live in a white area in which they are very 'visible' and therefore vulnerable to racial harassment and attack. These threads in the survivor accounts illustrate how difficult it is for South Asian women to find a 'safe' place.

These strategies for survival clearly have implications for how accessible 'traditional' South Asian community organisations may be to such women and they also have particular significance for those mainstream organisations who may feel that due to smallness of numbers of South Asian people in their localities, they do not need to provide services to this group.

Domestic Violence and Immigration

The arrangement between what might be called the 'private club' (white, racist state patriarchy) and its 'gatekeeper' (South Asian patriarchy) gives rise to the potential for the exploitation and abuse of women as evidenced particularly in one of the survivor accounts in relation to the 'one year rule'³. As illustrated, the state can be seen to be an active partner in the violence against women. Despite recent concessions to the one year rule, it is unlikely that this will make any material difference to South Asian women in this situation. The evidence also illustrated how the key principle in welfare policies of the 'safety net' does not apply to this group as they have no recourse to public funds. Central to this analysis are the concepts of the shifting and different 'public' and 'private' spaces available to citizens and non-citizens.

Survivors' Experiences of Services

Survivors had come into contact with a wide range of agencies including: social services, education, police, housing and benefits agencies, primary and secondary level health care, specialist South Asian mental health services and women's refuges. Survivors' experiences of these agencies points not only to a failure of a wide range of services in meeting the needs of South Asian women, but also how services often (unwittingly?) put them at further risk. The evidence also indicates that South Asian women's first contact with services is when they are in crises, rather than at earlier, less acute points. The main service sector that was viewed positively by survivors were women's refuges. Other services such as a specialist South Asian

mental health project, as well as some statutory sector services were also mentioned positively. Overall, it can therefore be concluded that service interventions which engage both with the practical (e.g. housing, benefits etc) as well as emotional support are well received by survivors. Significantly, the South Asian women's refuge⁴ also makes efforts to work with women who have no recourse to public funds because of their immigration status. As is also illustrated in various studies (e.g. Davies and Betteridge, 1997; Shepherd et al, 1994; Slade et al, 1995), mental health service users themselves think that proper housing and an adequate income are some of the most important aspects to care.

Experiences, Meanings and Feelings

The analysis then moved on to consider individual experiences of distress and the meanings and feelings associated with suicide and self-harm. For all the survivors interviewed, there was a recognition of an escalation or build up of emotion relating to their particular situations. Feeling scared, alone, hurt, betrayed, alongside thoughts about self-harm or suicide, although present for some time were often intensified by a 'trigger' event which precipitated a suicide attempt or self-harm. Lack of fear in hurting oneself was also evident and appeared to be linked in some ways to experiencing a sense of power and control, normally not available to them. Together with the sense of power and control to end their lives or to hurt themselves, also came a contradictory set of feelings: guilt, fear and regret. For the women who self-harmed, self-harm was seen both as a coping mechanism but also as a way of punishing themselves as they blamed themselves for being 'bad'.

Most survivors found their families' responses after their suicide attempts or self-harming to be very punitive and uncaring. This was mirrored for many survivors in the attitudes of mental health workers and in the failures of services as outlined in the report. Firstly, it is urged that risk assessments in various settings, but particularly in A&E departments, need to give due regard to the sort of 'care' women are going to receive within the family. Idealised notions of strong family values in South Asian cultures need to be tempered by an understanding that families can also be a site of oppression for women – just as white families are. Second, the strong feeling of survivors that they were not 'heard' or understood, either by their families or by mental health workers, alerts us to the need to attend to the process of understanding – a quality that many mental health workers (and their managers) may mistakenly take for granted. It is therefore not surprising that in terms of services, what survivors think would better support them are workers who are more understanding and who have time for them. Third, the accounts also articulate the need for working in a way which recognises and values people's strengths, that resists labelling, and that works with an understanding of distress rather than solely with the symptoms of distress.

⁴ Although largely working with South Asian women, this refuge has also worked with Chinese women, women from the Philippines and Muslim women from Africa and the Middle East.

Survivors' Suggestions for Improvements and Developments

Survivors' groups emerged as a potential source of help and many survivors felt that these should be developed. In terms of other service interventions which they had not necessarily been offered, but which were perceived as potentially helpful, these included counselling (in first language rather than through interpreters), massage, aroma therapy and other complementary therapies. Ideas for reaching South Asian women included better publicity of services, community education and a telephone help line. However, these interventions also need to be developed within the overall context of systemic issues such as immigration, housing, poverty, sexism and racism as was also clearly identified in the survivor accounts.

Survivors' Strengths

What is very evident in these survivor accounts, is that far from the usual construction of South Asian women as passive and accepting of oppression, women have fought and survived systems of oppression based on class, racism and sexism and have also challenged cultural norms of South Asian communities at great emotional (and often physical) risk to themselves. Furthermore, they have often achieved this despite the general lack of care and consideration shown to them by 'helping' agencies.

D. COMMUNITY PERSPECTIVES

Following a collaboration between the Mental Health Needs Assessment/ Commissioning Project and the Health Action Zone Research Project, Colsom Bashir has been responsible for conducting and authoring the Community Perspectives section of the research.

The aim of ascertaining community perspectives was to encourage Asian women to share their perceptions of experiences of mental distress, and attempted suicide and self harm and to comment on barriers preventing access to service provision. The information produced has allowed for the identification of a number of indicators of good practice in relation to Asian women and service provision.

Definitions of Mental Distress, Attempted Suicide and Self Harm

All the focus group's initial responses referred directly to a range of systemic issues including social, political and economic pressures (domestic violence, poverty, language problems, children's issues, health etc.) that resulted in mental distress, and experiences of attempted suicide and self harm. However, the younger women named particular symptoms or specific disorders in relation to mental distress (depression, mood swings, anger etc). Further prompting brought out clear examples of methods of self harm and suicide and raised issues around self

harm as a coping strategy in response to external pressures. The overall theme to emerge was how the powerful combination of external pressures and systemic issues resulted in an extreme sense of isolation.

Factors Contributing to Asian Women's Experiences of Attempted Suicide and Self Harm

Once again clear systemic issues (poverty, racism and sexism) emerged as major contributing factors to women's experiences of mental distress, attempted suicide and self harm. The strong sense of affirmation of 'race' identity and negation of gender identity in one's own community and the mixture of both gender and race discrimination in the wider community contributed to silencing women and led to increased isolation. These experiences were reinforced by an extremely efficient community grapevine and were evident in experiences such as: racism and stereotyping of Asian women, Asian communities and Islam, the concept of Izzat (Honour) in Asian family life as a major influence in the lives of Asian women, language issues and domestic violence.

Community Support and General Service Provision

As a result of the efficient community grapevine, judgmental approaches and responses from mainstream service providers, all participants overwhelmingly expressed a strong sense of mistrust of 'conservative' Asian community organisations and most professionals in mainstream service provision. Particular non conservative organisations (Asian women's refuges) which were seen as radically supportive of Asian women's needs were more likely to be seen as sites for help than health and social care agencies. However participants did not have any real methods of judging which organisations (or workers) were collusive and others that were supportive, apart from direct experience in crises, which was considered risky and unsatisfactory. Participants also argued that services tended to be accessed only at a point of desperation, rather than prior to crisis points, which indicates the need for services to be able to respond rapidly when Asian women do ask for help. Participants expressed a preference for services to be promoted to them face to face so they could get a clearer idea of organisational values and accessibility. This indicates the need to find creative methods for health and service promotion, to be transparent about organisational values, and to explicitly address systemic issues which affect Asian women's lives.

Bangladeshi women expressed a real sense of dissatisfaction with interpreter services. They argued that in situations where privacy was required (family planning issues, sexual health), they would not be able to speak through interpreters, therefore first language services were preferred.

The majority of participants, apart from one, expressed a preference for working with Asian women workers who they proposed would better understand their position. However a great deal of mistrust was felt of such workers in the event that they had contact with local Asian communities. Examples of methods that might be effective included: services where Asian workers were recruited from outside the area; local Asian workers, (and other staff) were clearly informed about the consequences of colluding with oppressive societal and cultural values for Asian service users. This indicates a clear need for services to pro-actively work on issues of confidentiality with all staff and with Asian women to build trust and therefore increase accessibility.

A number of indicators for good practice were drawn up in relation to addressing systemic issues in service provision: service provision philosophy, recruitment, methods, language and assessment, publicity and health promotion, crisis services, effective partnership working with radical supportive Asian women's organisations, first language services and evaluation of interpreter provision.

The Community Perspectives aspect of the research examined particular experiences of the Asian community in relation to mental health problems as opposed to mental well-being. It might be argued that if the research approached the question from a well-being perspective then some of these issues may not have emerged so clearly. Alternatively, the more positive aspects of the context of Asian women's lives may have emerged. Additionally, targeting a group to discuss problems within and outside particular communities might also lead to further labelling and stereotyping of those communities. However, it is our view, that this research has both resisted stereotypes and has a valuable contribution to make to the development of appropriate services.

E. CONCLUSION

The report concludes that South Asian women are seldom given adequate priority in service planning, commissioning or provision of mental health services. It argues that there is no room for complacency and that mental health services need to understand how their policies and practices serve to exclude and marginalise South Asian women. It is therefore urgent that commissioners and providers take constructive action to redress the balance. To this end, the report makes specific recommendations to further understandings and actions in the area of suicide and self-harm in relation to South Asian women.

F. RECOMMENDATIONS

The following recommendations have been formulated on the basis of the discussions, evidence and analysis presented in the report. Whilst they have emerged from the specific considerations of South Asian women, attempted suicide and self-harm and service responses to this, clearly

there are links with wider issues of 'race', gender and mental health commissioning and provision. In particular, attention is drawn to the need to challenge racism and sexism at all levels, both within Manchester, Salford and Trafford HAZ, and beyond, including legislation and national policies which disadvantage and oppress Black communities, service users and carers.

Recommendation 1

Management Development Program for Senior Managers (Commissioners and Providers)

Aim: To help senior managers develop and operationalise a HAZ wide and an individual agency perspective to gender-sensitive, anti-racist work in relation to suicide and self-harm services to South Asian women.

Such a program should address issues such as: the current invisibility of the consideration of the needs of South Asian women, the privileging of 'race' over gender in commissioning, partnership arrangements and service provision, contributory factors to South Asian women's suicide attempts and self-harm, the need to make representations at a national level to challenge legislation and policy which disadvantages South Asian women and other Black people, and the need for non-medicalised services, and service specifications, evaluation and monitoring processes that are inclusive of South Asian women.

Recommendation 2

The Development and Implementation of a Staff Development Strategy (for mainstream and South Asian organisations)

Aim: To help mental health practitioners develop sound gender sensitive, anti-racist practice and to work competently with South Asian women with issues of suicide and self-harm.

Such a strategy should enable workers to understand the interconnectedness of the impact of racism, sexism and other oppressions on themselves and others, to challenge the 'colour blind' approach and dominant hierarchies within 'helping' relationships, understanding of the contributory factors of suicide and self-harm in South Asian women leading to more accurate risk assessment, care and treatment, safe guarding confidentiality, developing skills in working inter-culturally, and counselling skills.

Recommendation 3

Non-managerial Case-work Supervision and Support for Mental Health Practitioners and Link Workers (All sectors)

Aim: To ensure safe practice, provide support to practitioners to address the complexities of working not only with issues of 'race' and gender, but also attempted suicide and self-harm.

Recommendation 4

The Development and Implementation of More Inclusive Partnership Working Arrangements with South Asian Women

Aim: To rectify the current omissions in partnership arrangements, particularly of South Asian women, to recognise the consequences of partnerships with 'conservative' South Asian groups, to address issues of tokenism, to recognise and address power dynamics within partnerships and to ensure that mainstream agencies do not abdicate responsibility onto South Asian groups.

Recommendation 5

Strengthening the Role of South Asian and Other Women's Refuges, and Other Gender Specific, Anti-racist Services

Aim: To recognise and work in non-exploitative partnership with a currently unrecognised source of support to South Asian women with suicide and self-harm issues by increasing resources in this sector to further develop innovative practice and to respond to the needs of South Asian women (and other women) subject to the 'one year rule'.

Recommendation 6

The Development of a Properly Resourced Women-only Collaborative Forum Working on Issues of Suicide/Self-harm and South Asian Women

Aim: To counter the current culture of competition between agencies and to promote joint working and innovative practice in this area of work between agencies, senior managers, practitioners and survivors.

Recommendation 7

The Development of Core Funding Strategies for Voluntary Organisations Working with South Asian Women and Attempted Suicide and Self-harm

Aim: To recognise and recompense for the additional requirements of commissioners in relation to monitoring and evaluation, to recognise that partnership working requires time and resources and to allocate resources specifically for the development of innovative practice and campaigning work, or to increase capacity within voluntary organisations to raise funds independently of the statutory sector.

Recommendation 8**The Development of a Black Women's Counselling and Complementary Therapy Service**

Aim: To be part of a suicide prevention service development to respond to the needs of South Asian women (and other black women) for confidential counselling in relation to feelings of attempted suicide, self-harm as well as other mental health issues by developing and drawing upon non-medicalised, gender-sensitive, anti-racist ways of working.

Recommendation 9**The Development of South Asian Women's Survivors Groups**

Aim : To develop facilitative and supportive groups to break isolation, share experiences and build on survivors' strengths.

Recommendation 10**Provision of Safe and Supported Housing for South Asian Women in Distress, Including South Asian Women Attempting Suicide**

Aim: To work in partnership with other agencies providing housing with mental health support to address the need for both practical and emotional support, to provide accommodation for women who have no recourse to public funds, and to have a practical alternative to back up risk assessments where returning to the family may pose further threats to well being.

Recommendation 11**To Support Voluntary Organisations to Develop an Immigration Welfare Fund**

Aim: To set up a non-stigmatising, quickly accessible source of funds, to respond to the needs of South Asian women (and others e.g. asylum seekers) who have no recourse to public funds due to their immigration status.

Recommendation 12**Effective Use of Child Protection Policies and Procedures**

Aim: To address potential gaps in the implementation of child protection policies and procedures (as indicated in the survivor accounts) in relation to South Asian children and young people and to acknowledge and act upon the links between domestic violence and child protection issues.

1 INTRODUCTION

This research study on service responses to attempted suicide and self-harm in relation to South Asian women was commissioned by the Manchester, Salford and Trafford Health Action Zone (HAZ), over a ten month period from June 2000 to March 2001. It was conducted by Khatidja Chantler (Independent Researcher) in partnership with the Women's Studies Research Centre of the Manchester Metropolitan University (MMU). The staff from MMU were Professor Erica Burman (Department of Psychology and Speech Pathology) and Janet Batsleer (Department of Applied Community Studies). Partnership arrangements were also negotiated with the Central Manchester Primary Care Trust's Mental Health Needs Assessment/Commissioning Project for the community perspectives strand of this study. The community perspectives part of the study was conducted by Colsom Bashir.

1.1 The National Context

This study was set in the overall national policy context of reducing suicide and undetermined injury by at least a further sixth by 2010 (Our Healthier Nation) as well as the National Service Framework for Mental Health, which makes the prevention of suicide one of its key priorities.

1.1.1 Measuring Rates of Suicide

Measuring rates of suicide is complex and there has been much debate about whether suicide rates are a 'true' reflection of suicide rates (e.g. Chambers and Harvey (1989), Kleck (1988)). Part of this difficulty lies in being able to establish with certainty whether or not somebody intended to kill themselves and it is the task of the coroner's court to determine this. As Chambers and Harvey (1989), indicate, circumstances are often very ambiguous, and coroners may be reluctant to return a verdict of suicide not just because of uncertainties, but also to protect the feelings of family members. The alternative of 'open verdict' or undetermined injury is often made and as "the majority of open verdicts are suicide...it is conventional to include some or all open verdicts in studies of suicide" (Safer Services - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (1999: 15)). Within this, the current measurement is that there are just over 4,000 deaths from suicide a year (Kelly and Bunting 1998, Chief Medical Officer 1998).

1.1.2 Rates of Suicide, Ethnicity and Gender

In addition to the complexities outlined above, the rates of suicide for minority ethnic groups

is even more obscure. Whereas national figures breakdown the number of suicides by age and gender, they do not indicate ethnicity, as death certificates do not ask for this information. Secondly, even if information about ethnicity was collected, as has been noted by others (e.g. Hillier and Kelleher, 1996), defining ethnicity and ethnic groups is fraught with difficulties. Individuals' notions of their 'ethnic' identity is inevitably much more subtle and complex than the categories that have been created for example, by the last census and in many organisations' ethnic monitoring forms. Thirdly, is the concern about how such information is used with its potential for pathologising individuals and black cultures by reproducing and representing them as 'deficient'. Hence, whilst on the one hand the lack of more specific statistical information about suicide and minority ethnic groups means that these concerns do not come into play, it also may mean gaps in appropriate services for these groups are (unfairly) justified as there is no consistent measurement. However, an inadequate evidence base for lack of services has to be challenged, firstly in terms of what evidence is seen as acceptable. Secondly, a lack of statistical evidence should not be used as a rationale for the lack of sensitive services to particular communities.

The research carried out by Soni Raleigh (1996), based on country of birth, indicates that suicide is high in young Asian women, (15-24 years) compared to other ethnic groups. Although a high rate of suicide (for young women) was found in all four groups studied: Bangladeshi, Pakistani, Indian and East African, Indian and East-African women had the highest rates at both ages 15-24 and 25-34 years. Studies by Merrill et al (1986, 1990) indicate that risks are high in UK born Asian women too. As Soni Raleigh also notes, the high rate of suicide and attempted suicide in young Asian women is consistent in the international literature (e.g. Flisher and Parry 1994, Adityanjee, 1986, Kok 1988).

1.1.3 High Risk Groups of Death by Suicide (National Service Framework)

Certain groups are identified as being at higher risk of suicide within the National Service Framework for Mental Health (NSF). Included in this are, "among women living in England, those born in India and East Africa have a 40% higher suicide rate than those born in England and Wales" (1999:77). Significantly, the NSF does not make it clear here that this refers to Asian women, although these figures are based on the work of Soni Raleigh as discussed above. There may also be a danger that the quoted statement from the NSF may obscure the needs of South Asian women from Pakistan and Bangladesh as well as UK born Asian women. Additionally, within the NSF's identification of groups at higher risk of suicide, there is a noticeable gender 'neutrality'. Whereas people (disproportionately women) who have experienced, or are experiencing domestic violence and sexual abuse are mentioned early on in the NSF document as being vulnerable to mental distress, this does not feature in the groups identified as being at higher risk of suicide. This omission is surprising given the growing evidence linking abuse with self-harm - hence although self-harmers do feature in those identified at higher risk of suicide, specific mention of sexual abuse or domestic violence is not made. As Liebling et al, in their study of self-harm found: "Sexual, physical and

psychological abuse were common and self-harming was cited as a way of coping with these experiences.” (1997:431). Links between abuse and self-harming and attempted suicide have also been found in other studies (e.g. Yazdani 1998, Spandler 1996). Therefore central to this project is an alertness to how ‘race’ and gender intersect, and the consequences to South Asian women of marginalising either ‘race’ or gender.

1.1.4 Mental Health, ‘Race’ and Gender

There is a substantial body of evidence (e.g. Ahmad, 1992; Fernando, 1991; Littlewood & Lipsedge, 1982) that illustrates the inequalities in the access to and treatment of Black people within the mental health system, and the institutionalised racism inherent within psychiatry and mental health work. However, much of this work is not gender specific, and therefore does not pay enough attention to the position and treatment of Black women (Burman et al, 1998). Equally, there is also a substantial body of work focusing on women and mental health which also excludes the specific and distinct experiences of Black women (Aitken, 1996). In particular, the invisibility of South Asian women’s experiences within discourses of mental health is very noticeable. Hence the recent Newham study on young Asian women and self-harm (Yazdani, 1998) and this study make valuable contributions to this area of work.

As the National Service Framework for Mental Health states:

“Combined evidence suggests that services are not adequately meeting mental health needs [of black communities], and that black and minority ethnic communities lack confidence in mental health services.” (1999: 17).

1.1.5 The Wider Context

The importance of wider contextual issues are crucial to the development of sound policy and practice interventions in mental health, as in other fields of social policy. The links between mental health and economic deprivation are widely documented widely (e.g. Acheson 1998, Fox and Shewry 1988). The position of the majority of Black communities, (including South Asian communities) living in inner city areas, and the economic position of Black women within this also need to be noted.

Other contextual issues that are especially relevant for this study are the prevalence of racism and sexism in structural, institutional and interpersonal forms, the efforts made to combat these at a national level, and their repercussions – both nationally and in local contexts. Attempts at countering discrimination have largely been through the introduction of legislation, specifically the Race Relations Act (1976), the Sex Discrimination Act (1975) and more recently the Disability Discrimination Act (1995).

These legislations make it unlawful to discriminate (directly or indirectly) against women, or to discriminate on the grounds of colour, race, nationality or ethnic origin or to discriminate against disabled people, both in terms of employment practices and in the provision of services. However, what is clear is that these pieces of legislation are insufficient to eradicate racism, sexism or disablism.

One key way in which this is evidenced is in the onus placed on individuals to prove that they have been discriminated against rather than on organisations to prove that they operationalise equality policies on 'race', gender or disability. Secondly, the legislation and its related structures (e.g. The Equal Opportunities Commission) fail to engage with the intersections between various oppressions, thus leaving for example, Black women poorly protected. So Black women approaching the Equal Opportunities Commission for assistance have frequently been told to contact the Race Equality Council instead and vice versa. Thus both these structures either privilege 'race' or gender, rather than recognising the necessity of working with both 'race' and gender. Clearly, these structures and modes of thinking have also had a significant bearing on the equal opportunities policies of many local and health authorities. Thirdly, the social and political context, particularly in relation to 'race', throws light on the constructions of black people as "problems". The main way in which this is manifested is via immigration legislation, where concern to reduce numbers, media and government attention on 'bogus' asylum seekers, economic migrants, and 'dispersal' policies all represent minority groups as strange, alien, unwanted and problematic. Hence, the problem is not identified as racism, but the black presence: the fewer black people there are in the country, the better it is for "race relations". This view has persisted despite evidence to the contrary, for example, the substantial increase in reported racial attacks. Far from improving "race relations", it could be argued that legitimising racism in the form of stringent immigration laws, only encourages racist attacks.

Hence in terms of the specific concerns of this report, it is important that the problem is not seen to reside in, or with, Black people or communities, but in the contexts and services whose responsibility it is to support them.

1.1.6 'Race' Anxiety

One of the key barriers to implementing 'race' equality policies is the reluctance to acknowledge the prevalence of racism at structural, institutional and personal levels. In 1999, the publication of the MacPherson report and its aftermath, especially within the Police Federation illustrates well the confusion around understanding the dynamics of racism, and the sense of shame and outrage (organisationally and personally) associated with being labelled 'racist'. Clearly, this sense of shame and anger is not restricted only to the police, but reflects processes at a wider societal level. Being labelled racist does not sit well with perceived British sensibilities of 'fair play' and 'justice'.

At an institutional and personal level, much of the effort to implement 'race' (and gender) equality policies is characterised by 'political correctness'. Some of the emphasis here has been to change the language that people use without changing institutions at a more fundamental level. Moreover, one of the consequences of political correctness has been to silence workers and organisations; silence being the safest option when discussing contentious issues which could lead to 'naming and shaming' either personally or organisationally. Hence difficult issues are hidden, and made invisible and yet it is this very invisibility and silence that contributes significantly to the perpetuation of institutional racism.

It could also be argued that the appropriation of the term 'political correctness' by the New Right is a further barrier to equality. In this context, those who are 'politically incorrect' are portrayed as victims, thus firstly, shifting attention away from the substantive issues of 'race' and gender inequality, and secondly by creating a culture where it is much more difficult for those who are committed to challenging oppression to do so.

Therefore a study such as this, which seeks to inquire about mental health services for South Asian women, not only has the potential for discomfort and embarrassment for both interviewers and participants along lines of 'race', but also in the discussions around suicide and self-harm which evoke equally powerful feelings.

1.2 The Local Context

Local contexts are influenced and shaped by the national context as outlined above. This applies both to specific government initiatives in relation to mental health as well as the wider economic, social and political context.

Returning to a more local level, suicide rates within the Health Action Zone are high. They are highest in Manchester, followed by Salford and then Trafford (Health through Action, 1999). From the data currently available, there is no indication of the suicide rates of Asian women within the HAZ area. Despite this, within the HAZ's mental health action plan, the target is to reduce suicide rates for Asian women by 5% by 2002.

1.3 Background to the Research Project

In June 1999, a meeting was held between M, S & T Health Action Zone and Asian women to explore the issues of suicide and self-harm. It emerged that one way forward would be to establish through a mapping exercise, some baseline data of services that provide help and support in this area of work. In March 2000, a conference (funded by HAZ) entitled "South Asian Women at risk of Suicide and Self-harm" was held in Manchester, organised jointly by 42nd Street and the South Asian Women's Mental Health Coalition (SAWMHC). The conference made recommendations on how work in this field could be carried forward.

At the same time, in addition to the mapping exercise, a revised research proposal was developed by this research team which aimed to provide a more comprehensive and in-depth exploration of attempted suicide and self-harm and service delivery to South Asian women. It needs to be acknowledged that there was some tension between whether a further piece of research was necessary given the recent publication of a report on young Asian women and self-harm by the Newham Asian Women's Project (Yazdani, 1998). It was strongly felt by the SAWMHC that action on the recommendations of the March 2000 conference was more urgent than a research study. However, the revised proposal was accepted and funded by HAZ. Clearly there are tensions between funding research and funding service developments in the context of scarce resources, and it remains to be seen whether the recommendations from this report and the March 2000 conference will now be implemented.

From the report of the June 1999 meeting, it is clear that the South Asian women present, did not feel that mainstream services were accessible to South Asian women. Research (e.g. Mercer, 1986) would also support the view that western approaches to mental health treatments are often found to be unsuitable and culturally inappropriate to the needs of South Asian and Black communities. The above report also emphasised that South Asian women best know the problems they are experiencing, and therefore the solutions are similarly likely to be found amongst these same individuals/groups. However, at the same time it is plain that the responsibility for developing policy and practice in the complex field of attempted suicide and self-harm cannot be the sole responsibility of South Asian communities, but requires a multi-agency approach with effective partnership arrangements and adequate resourcing. Specifically, this involves building on the strengths, creativity and experiences of South Asian communities, particularly women, in a manner which does not further exploit or oppress them. It needs to be noted, that the research undertaken was not a prevalence study, but rather its focus is on perceptions of, and responses to, available services.

Within these understandings, the overall purpose of this research is to contribute to the development of and improvements in access to sensitive, relevant and appropriate services to South Asian women in relation to attempted suicide and self-harm.

1.4 Objectives of the Research

The primary purpose of the study was to conduct a qualitative study of suicide and self harm services in relation to South Asian women in the HAZ area in order:

- To compile a service map of potential sources of help.
- To identify the current level and appropriateness of services being offered to South Asian women who self harm and/or are suicidal.
- To increase understanding of the specificities of the factors contributing to the distress of South Asian women.
- To identify examples of good practice.

- To identify gaps in service provision to this service user group.
- To make recommendations to improve self-harm/suicide services to South Asian women.

1.5 Values, Beliefs and Research Approaches

To undertake a research study that has identified a distinct group (South Asian women) based on gendered and racialised identities presents many challenges. Central to these challenges are concerns, firstly, about the essentialising of such identities, that is, treating them as stable and fixed rather than contextually and relationally constructed. However, it is argued here that the invisibility of the experiences of South Asian women at a wider social and political level and in the policies and practices of mental health agencies means that a focus on this group is in itself a challenge to the universalisation of experience, policy and practice. Hence this study provides an opportunity to engage with the specificity of South Asian women's experiences of distress and their experiences of helping agencies.

The second challenge revolves around how such gendered and racialised identities are represented. In particular, it is important to recognise the power inherent in research processes to (re)produce 'knowledge' based on existing negative constructions of marginalised groups (Bhavnani, 1991); in this study South Asian women. Following this, within this study, in exploring the contributory factors to South Asian women's attempted suicide and self-harming and their meanings, it is hoped that the reader will not conflate ideas about the oppression of South Asian women as integral to South Asian cultures without making the corresponding links to the oppression of women in white cultures. Significant also, is the often unspoken alliance between white, racist patriarchy and South Asian patriarchy. Hence the difficulties in highlighting issues of abuse, violence and distress in South Asian communities, include how these aspects tend to be over-emphasised in many contexts (e.g. through the media), giving rise to racist interpretations of South Asian communities. Furthermore, in a parallel process, the racist environment within which we live can also contribute to the under-emphasising of issues of abuse and violence in South Asian communities by those who reify such communities or those who are afraid that they may be perceived as racist.

Hence key to our study has been our concern that this research does not perpetuate those constructions and, in so doing we have also sought to challenge stereotypical perceptions of South Asian women as passive victims, and of assumptions of South Asian communities as homogeneous along lines of gender and class. An engagement with the dynamics of power (individual, community, organisational and structural) has therefore been integral to the design, conduct and analysis of the study. Always in view has also been our belief that such a study could be an impetus for positive change and this has been the main driving force in undertaking this work. Hence the perspectives that have most influenced this work are based on black feminist (e.g. Brah, 1987; Parmar, 1989) and action research approaches (Banister et al, 1994; Kagan and Burton, 2000).

1.6 Research Design and Methods Used

As the overall purpose of the research was to contribute knowledge and understanding to the development of services in relation to South Asian women, in the HAZ areas, key stakeholders were identified to generate a range of perspectives as follows:

- South Asian women survivors of attempted suicide and self-harm
- Mental health workers in a wide range of settings
- Senior managers in key services
- South Asian Communities

1.6.1 South Asian Women Survivors

The aim of this part of the research was to increase understanding of issues of self-harm and attempted suicide as perceived by South Asian women who self-harm or who had attempted suicide. As Spandler's (1996) work clearly demonstrates, the perceptions of those that self-harm is that self-harming is often a way of regaining some measure of control. This may be in direct contrast to how self-harming and suicide attempts may be viewed by professional helpers. Many professional helpers may see self-harming as 'deviant' and may see their primary responsibility as enabling the client to stop self-harming. Given that there are different meanings attached to attempted suicide and self-harming behaviour, the focus of this part of the study was to understand self-harming from the South Asian women's perspectives. An important part of this would be to hear and document their stories, acknowledging both their vulnerabilities as well as their strengths and coping mechanisms. The interviews also sought to gain an 'insider's' view of the services used, as well as what support is perceived to be helpful/unhelpful. This seemed especially important given the relative 'invisibility' of South Asian women within current discourses and practices around gender, 'race' and distress.

The ethics of interviewing women on such a sensitive subject matter were fully considered and this was reflected in the process of contacting potential participants, arrangements for extra support, negotiation of confidentiality, conduct of the interviews and in the analysis presented. In depth, loosely structured interviews, were facilitated in the interviewee's language of choice. In total, 7 survivor interviews were held.

The chronology of the process was important, therefore interviewing survivors first was seen as crucial to informing the other strands of the research. Whereas the needs and concerns of South Asian women survivors were seen as an integral part of the research, equally important was the consideration of the roles, responsibilities and understandings of helping agencies in this area of work.

1.6.2 Mental Health Workers

The major resource of any helping agency is its staff. Therefore the engagement of staff in a wide range of settings, in the statutory and voluntary sector was seen as a crucial part of the research. Hence the research process offered not only an opportunity to explore staff's views on issues of attempted suicide/self-harm in relation to service provision to South Asian women but also in so doing, facilitated matters that were previously 'invisible' to become 'visible'.

It was therefore thought that semi-structured group discussions with workers would be the most appropriate way forward. However, in the event, this did not prove to be feasible in all settings and individual interviews were set up where group discussions were not possible due to staff shortages or availability. More specifically, the discussions sought to gain an understanding of the views and concerns of workers in relation to the accessibility of their service to South Asian women, examples of good practice, gaps in service, barriers to providing sensitive services, working in partnership, staff development issues and suggestions for ways forward.

A total of 18 discussions were held and included the following: GPs, community psychiatric nurses, nursing staff on psychiatric wards, health visitors, consultant psychiatrist, social workers, counsellors, mental health support staff, staff from specialist South Asian mental health services and women's refuges.

1.6.3 Senior Managers

As key decision makers about resource allocation and the configuration and overall management of services, the involvement of senior managers was seen as essential if the research was to result in changes or development of services to South Asian women. Senior management perspectives on how mental health services for this group are planned for and delivered, particularly in the context of the National Service Framework for Mental Health and other national policy initiatives, were important topics for exploration, as were issues of working in partnership with South Asian community groups, mental health organisations, service users and carers. The current changes in the organisation of mental health services could also provide a window of opportunity for incorporating the mental health needs of South Asian women - a largely hidden and traditionally hard to reach group.

8 in depth interviews were held with senior managers (commissioners and providers) from the statutory and voluntary sectors. The interviews sought to both explore issues as identified above, plus broader policy and management issues, and also to discuss some of the initial findings from the survivor accounts.

1.6.4 Perspectives of South Asian Communities – Women’s Groups ⁵

The aim of this part of the study was to form impressions of how issues of self-harm, attempted suicide and mental distress are viewed within South Asian communities. In addition, views were also gathered on knowledge of existing sources of help, perceptions of such agencies and what key changes (if any) needed to take place to improve service delivery to their community. This part of the study was also seen as an opportunity to invite open discussion of issues of mental distress, and thus to combat the stigma of mental ill-health, apparent in all communities. The rationale for consulting with women only groups was firstly, to ensure that women’s voices were heard, as frequently consultations with minority ethnic communities are carried out via ‘community’ leaders, usually men. Secondly, women are more likely to be carers than men, hence they may be particularly alert to issues for carers (whether of children or of distressed or disabled relatives and friends). Clearly, decisions also had to be taken regarding which South Asian communities were to be consulted. The demographics within the HAZ area and discussions within the research steering group indicated that the Pakistani, Bangladeshi and Indian communities would be contacted. Due to the earthquake in Gujarat, India, and the links that the Indian community have with Gujarat, it was not appropriate to continue negotiations with them about this research within the time scale of this project. Therefore the communities consulted were the Pakistani and Bangladeshi communities.

4 women’s group discussions were held, in the language of choice of the group.

1.6.5 Map of Potential Sources of Help

Through the process of the research as described above, it has been possible to draw up a map of potential sources of help for South Asian women who self-harm and/or are suicidal. This was largely through networking with workers, other researchers, womens groups, personal contacts and local knowledge of services. The service map is in Appendix 1.

1.7 Analysis

Interviews and discussions were analysed using a thematic approach. Summaries were written for each interview either from detailed notes or selected transcriptions, from which key themes were identified (Banister et al, 1994). These were then compared to the others in their group for both similarities and differences. Each cluster of interviews was then analysed in relation to other clusters, drawing out parallels and contrasts. A range of views as well as the most commonly discussed views are presented. The analysis is both interpretative and also presents verbatim examples from participants to illustrate salient points.

⁵ This part of the study was conducted by Colsom Bashir, Central Manchester Primary Care Trust – seconded from the Mental Health Needs Assessment/ Commissioning Project.

To enable each stake holder's perspective and the issues pertinent to them to be understood clearly, each of these perspectives is presented separately with links made to the other strands of the study. We have chosen to present the senior managers' perspectives at the start of the analysis to emphasise their key responsibilities in the management and delivery of appropriate mental health services to South Asian women. This is then followed by the worker discussions. At the heart of the report are the survivor accounts which are juxtaposed between organisational responses and South Asian community responses to their distress. Throughout the report we have also highlighted indicators of good practice arising out of the interview material and analysis. We end the report with our conclusions and recommendations which we would urge you to act upon.

2 SENIOR MANAGER PERSPECTIVES

Decision making about the level and type of services provided rests primarily with senior managers. It is senior managers who have the power to shape and define organisations, recruit staff, allocate resources, set goals, develop policies and ensure their effective implementation. It further needs to be acknowledged that the allocation of resources via service commissioning and service developments are not politically neutral activities. In all these ways, senior managers heavily influence the culture and practices of their organisations. If mainstream services are to provide sensitive and relevant services to South Asian women, then managers meaningful engagement with the issues is crucial.

2.1 Contacting Senior Managers

Deciding who to contact was not an easy process as firstly, many mental health services are in the process of change, both within the national context (e.g. National Service Framework for Mental health, the creation of Primary Care Trusts) and more locally (services/ commissioning reconfiguring differentially). Secondly, many key people had only been in post for a short period. This offered the opportunity for the study to engage at a potentially timely moment in the hope that the needs of South Asian women attempting suicide and self-harm would be taken into consideration in the reconfigurations of mental health services. On the other hand, newness in post and grappling with substantial changes creates anxieties of its own which could then be compounded by discussing sensitive issues around 'race', 'gender' and mental health. In this study, senior managers were taken to be managers (including chairs) who had lead responsibility within their organisations either for commissioning or providing mental health services.

2.2 The Interviews

Semi-structured, in depth interviews were conducted by Erica Burman and myself with the senior managers of 8 organisations (voluntary and statutory) responsible for commissioning or providing mental health services across Manchester, Salford and Trafford.

The four interlocking areas covered by the interviews were: policy issues, service commissioning and deliver of services, partnership working and staff and management development.

(The interview schedule can be found in Appendix 3)

2.3 Confidentiality Arrangements

Interviews with senior managers were kept confidential. A list of participating agencies (including the worker discussions) are included in Appendix 2. Verbatim notes were taken in the interviews which were also taped - where permission was given by the interviewee. Tapes and notes from the interviews have not been seen or heard by anyone other than the interviewers. Interviewees were offered notes of the interview, and the emerging themes of the study were discussed at the end of the interview.

2.4 Introduction

The findings from the senior manager interviews are considered in the following way. Firstly, wider issues about the impact of the contract culture are discussed. Second, partnership arrangements with South Asian community groups, service users and carers groups are explored and the case to engage with minority voices within communities, particularly South Asian women is stressed. Third, attention is turned to senior managers understandings of the factors that contribute to South Asian women attempting suicide and self-harm. Finally, current configurations of mental health services to South Asian women are analysed; namely mainstream services, specialist South Asian mental health services and generic South Asian community groups.

2.5 Impact of the Contract Culture

The impact of the contract culture emerged as an important theme in the senior manager interviews. The following issues are considered: the relationship between providers and commissioners, evidence-based practice, evaluation of services, the threats to the autonomy of the voluntary sector, the consequences of competition and the role of niche markets.

2.5.1 The Relationship between Providers and Commissioners

The discussion of the roles of providers and commissioners gives rise to limitations of service interventions. Many providers felt that their hands were tied in terms of service developments as it depended on what the purchasers/commissioners wanted to fund. Commissioners were perceived as having the final say in what services were provided as they were the funders. An example of this was given in relation to counselling services at primary care level which the commissioners had decided was not a good use of funds. The senior manager's (provider) response:

"You and I might think differently."

So the implication is that if the commissioners of services were not aware of or interested in the needs of South Asian women then there would not be funds to provide a service to this group. On the other hand, the commissioners felt that providers were not particularly interested in the issues facing South Asian women in relation to suicide and self harm (or more generally) either. There is therefore a convenient silence between the two where the responsibility of providing services to this group is passed from providers to commissioners and vice versa.

However, it was acknowledged that the NSF did provide leverage with which to negotiate with commissioners – whether this will happen particularly in relation to South Asian women remains to be seen. This would appear to be the first time that South Asian women are identified as a group at risk (of suicide) within government documents such as NSF and could therefore provide an opportunity to develop innovative services.

Linked to the commissioning agenda in terms of funding services is the requirement for evidence based practice. This is particularly difficult when providing services for a hitherto hidden group (such as South Asian women with issues of suicide/self-harm), where there may well be a paucity of information or where the information available is not in a traditional, 'scientific' form. Also linked to both the commissioning and best value agendas is the need to ensure that services being provided are evaluated.

2.5.2 The Need to re-conceptualise Evidence-based Practice – Suicide and South Asian Women

As death certificates do not ask about ethnicity, there is no national or locally available information of mortality rates through suicide for South Asian women. Hence, the favoured data of health and social care planners – so-called 'hard' statistical data is not available for this specific group. This in itself highlights questions of hidden exclusion within current policy priorities. For the fact that there is 'hard' data identifying young men as a particularly high risk group meant that most interviewees did identify them as being at risk. The invisibility of South Asian women is thus heightened by their absence in mortality rates. However, the National Service Framework (NSF) does indicate that Asian women are a high risk group:

“among women living in England, those born in India and East Africa have a 40% higher suicide rate than those born in England and Wales”

(NSF, Page 77)

This evidence is based on the work of Soni Raleigh (1996) who used country of birth as a means to identify suicide rates in South Asian populations. Clearly, this does not take into account second and subsequent generations of South Asian women born in England and Wales. A further significant absence is the omission of Pakistani born women in the NSF

information (rather than in Soni Raleigh's study). It is widely assumed that Pakistani women, particularly Muslim women are not at risk of suicide because of the strong religious taboos in Islam forbidding suicide. However, all 7 survivors interviewed for this study described themselves as Muslims. It seems really important to highlight this, despite the dangers of fanning the already burning fires of Islamophobia, particularly in the context of the demographics of Manchester, Salford and Trafford where the largest South Asian minority ethnic group is of Pakistani Muslim cultural heritage. There is a danger that such cultural assumptions will work such that the needs of Muslim women will be denied and excluded based on the cultural assumptions associated with religion. On the contrary, what this should signal is the increased isolation experienced by Muslim women who may be experiencing suicidal feelings – as they may perceive themselves and be perceived by others, both within their own communities and by helping agencies as feeling and behaving against 'accepted cultural norms'.

Indicators of Good Practice

- Commissioners and Providers of mental health services through their policies and practices to explicitly acknowledge and engage with the higher rate of suicide in young South Asian women
- Recognition of potential of increased isolation of Muslim South Asian women due to religious taboos against suicide
- Recognition of absences of South Asian women (and men) within current figures available on deaths through suicide

2.5.3 Evaluating services

Trying to ensure that services commissioned from voluntary organisations are quality services is difficult. Commissioning organisations have agreements or contracts and contract monitoring procedures to ensure that the contract requirements are being fulfilled. However, this increases the number of tasks expected from voluntary organisations who are already over-stretched. It would appear that this form of monitoring also relies heavily on outcomes such as number of people seen/contacts made, number of sessions etc. In effect, organisations will be judged (by funders) on their outcomes – their viability will depend on whether or not they are able to meet their targets. The danger is that the vibrancy of the voluntary sector may well be stifled by the growth in bureaucratic procedures for monitoring effectiveness.

A commissioner:

“One of the issues is how much you can expect voluntary organisations to spend all their

time on outcomes – we were hoping to incorporate more discussions with service users more routinely.”

Furthermore, much of the work involved in supporting people either at “low intensity” or in crisis is about process and does not lend itself particularly well to outcome measurement. Undue emphasis on outcomes is likely to interfere or impede work with service users. Indeed such a fear was raised by staff at several voluntary sector organisations.

Indicators of Good Practice

- Clear and user friendly commissioning and monitoring processes
- Keeping tasks associated with commissioning, monitoring and evaluation to a minimum so as not to overburden voluntary sector agencies
- Providing support to new and developing agencies to commission successfully
- Ensuring that the process element of work is not overlooked in favour of outcome based criteria

2.5.4 Autonomy of voluntary organisations

Traditionally, the voluntary sector has spear headed many radical initiatives in the health and social care field. To what extent is it possible to continue doing this in the current climate? From the analysis, the autonomy of the voluntary sector emerged as curtailed in the following ways:

2.5.4.1 Tightly specified interventions

The main source of funding for many voluntary organisations, (including the one interviewed for this part of the study) is via winning contracts from funders. Contracts are very tightly specified, outlining interventions needed for individual clients including number of hours being purchased and the proportion of these that should be contact time. It was impressive that despite this, the organisation interviewed managed to provide a flexible and responsive service.

“It’s care managed because if it’s a spot purchase they would dictate the number of hours so that comes from social workers and CPNs. People on our books receive additional support regardless of package.”

Clearly the scope for innovative or campaigning work which are traditional strengths of the

voluntary sector, is restricted by this kind of funding arrangement. At a more general level, it could be argued that the contract culture has succeeded in 'silencing' the voluntary sector, with many of them abandoning a more campaigning style, settling instead for 'straightforward' service delivery – replicating and reproducing the priorities of their funders as required by the terms of their contracts. As we will indicate, the absence of this campaigning perspective gives rise to particular support gaps for South Asian women at risk of suicide and self-harm.

2.5.4.2 'Medicalised' Services

Linked to the above, is the 'medicalisation' or categorisation of interventions depending on mental illness diagnosis. Therefore such funding arrangements could also give rise to replicating the often coercive/controlling interventions of the statutory sector. Especially worrying is the division between people described as having mild to moderate mental health problems and those labelled as having severe and enduring mental health problems. Attempted suicide and self harm spans both such categories as well as (from survivor accounts) people who do not come into either of these categories as they would not see their behaviour as a mental illness – but as the only actions available to them in response to oppression and brutality. This latter group although benefiting from the lack of labelling, are on the other hand left completely on the outside of service provision. It would appear that there needs to be some new thinking about how to include this group within services whilst at the same time organising services that are freer from negative labelling. The implication at the moment is you can only be 'helped' if you are prepared to see yourself as somebody with 'mild to moderate' or 'severe and enduring' mental health problems.

Indicators of Good Practice

- Awareness of the impact of labelling
- Provision of services in a non-stigmatised form
- Space for innovation, creativity and campaigning for the voluntary sector

2.5.5 Competition rather than collaboration

It was felt that the contract culture made it very difficult for the various agencies (particularly voluntary sector) involved in mental health to come together to share ideas, learn from each other, develop new ways of working, training and other resources.

"Forums that used to exist, but don't now. The contract culture has made it harder to sustain collaboration, because of rivalry and competition – sometimes one feels it's almost deliberate."

The main reason given for this was that these agencies are competing for contracts from the same funders. So rather than providing 'joined up' services each organisation is fighting for their own corner. Whether intended or not, one of the consequences of the 'market economy' of welfare has been that the statutory sector, (particularly funders) remain in control by fragmenting and splitting the voluntary sector. Hence the supposed benefits of the market place e.g. choice for the consumer (i.e. service users) remain as elusive as ever.

2.5.6 Niche markets

Staying with the concepts of the market place, is the role of 'niche' markets. In this context, both attempted suicide and self harm as well as South Asian women could be considered niche markets. The senior manager of the voluntary sector organisation interviewed claimed to have been developing womens services since 1992 and within this service, they have always had Asian women clients and staff. In some senses it could be said that they have worked towards integrating their provision. However, now that funders appear to be interested in niche (or fragmented) markets such as Asian women and mental health, the organisation sees itself at a disadvantage as it is having to work at heightening its profile in relation to the work it already does with South Asian women in order to attract this niche funding.

"We've been working with Asian women for a long time and now working to give it a higher profile, to generate referrals."

Also,

"As a worker in (name of agency), I'm seen as an Asian working for a white organisation. They don't realise that I'm working to represent Asian people – a specific and specialised service, but this is not recognised. We're trying to convince referrers."

Some of this disadvantage may also be to do with notion that this agency is perceived as a white organisation (despite 20% of its staff describing themselves as Black or from an ethnic minority) to funders who may feel it more appropriate to contract services from South Asian organisations. Here there is a potential of some of the absurdities, dilemmas and complexities of 'matching' voluntary sector organisations (Burman et al, 1998) (as discussed later) to be played out at an organisational level, as well as being robbed of the opportunities to work together to develop innovative work in the mental health field.

Indicators of Good Practice

- Commissioners supporting collaboration rather than competition
- Recognising the value of integrated services as discussed above

2.6 Partnership Arrangements with South Asian Communities

Partnership and consultation are complex processes and the analysis offered here attempts to uncover some of the hidden and subtle processes involved in talking with South Asian communities, service users and carers. Consultation with South Asian communities was also seen as a key way, particularly in Manchester and Trafford to prevent suicide amongst South Asian women.

2.6.1 Diversity of South Asian Communities

Diversity within South Asian communities was seen primarily in terms of a national identity or religious affiliation rather than in terms of the complexities within specific communities centred around power and inequality e.g. gender relations, class or homophobia. Hence diversity within South Asian communities was mentioned in terms of Pakistani, Bangladeshi etc, and it was acknowledged that there were differences between groups in terms of language, religion and economic circumstances. It was also important to note that some of these differences e.g. in rates of unemployment were also a feature of class rather than ethnicity per se. There seemed to be a desire to know about the details of specific differences within each minority ethnic group before services could be appropriately tailored.

2.6.2 Desire for 'cultural' information

This desire for cultural information needs to be interrogated and evaluated. It is frustrating that such detailed information seems to be required to provide any kind of service to South Asian women. How meaningful is this level of information? What bits of 'cultural' information are necessary to know about and how might these relate usefully to individuals who will have their own interpretations of what it means to be a South Asian woman?. Moreover, these interpretations are likely to be different depending also on levels of acculturation, age, class, sexuality, experiences of racism and sexism, personal histories etc. The desire for 'cultural' information could be interpreted as yet another blueprint to make working with South Asian women simple and unthinking. At its worst it could be yet another tool with which to oppress South Asian women who do not 'fit' into the blueprint. A good example of this is the way in which the consequences of suicide and South Asian women, especially Muslim women was discussed above.

Furthermore, none of this kind of information seems to be necessary when providing services to white communities – where there is more acceptance of individuality. Points of commonality or sameness are also important – both within South Asian communities and between South Asian and white women. Throughout many of the discussions, no reference was made to the diversity within white communities and how this was managed in terms of providing services.

2.6.3 Many voices, not just one

Understanding about the complexities of “community” was mixed. However, even where the need to hear marginalised voices within South Asian communities was acknowledged, it was on the whole considered too difficult to do.

“It’s one of the things that we know, that every segment of every sector of the population needs to be heard, we are mindful of the deficiencies. How we go about rectifying this comes back to the issue of how much resource we put into user consultation.”

Furthermore, partnership arrangements (where these existed) tended to include the groups that are known about and even this is problematic.

“We recognise it’s quite difficult because there’s such a diversity of different cultures. I feel quite worried because we have meetings and people don’t find them easy to come along to.....difficult if you have too big a group, it’s difficult for people to participate.”

“We’ve tried to engage with community leaders and get them to tell us what to do.”

At a purely pragmatic level, senior managers are busy people and within the context of scarce resources, it is easy to understand why they would want an easy way of consulting communities rather than a more complex and time consuming option. However, the outcome of only consulting with community ‘leaders’ or visible Asian organisations headed up (usually) by men, is likely to be damaging and detrimental to the needs of South Asian women attempting suicide/ self harming. It is also easy to understand within this context why senior managers may prefer to hear one voice rather than the often conflicting voices that offer a closer resemblance to genuine “community” dynamics including gender inequalities in any community (see Martins, 2001). A real commitment to improving services to South Asian women needs organisations to challenge their own structures and ways of working and to think and act in more complex ways (requiring knowledge, skills and resources) then is currently the case.

A possible way round this that was suggested was to employ a liaison worker for minority ethnic communities – this was seen as more realistic in terms of time and resources than engaging with the complex dynamics of communities. Clearly, to be effective, such a worker would themselves need to work from a critical and committed perspective (and be supported in this) to ensure that they were not merely duplicating existing unsatisfactory partnership arrangements. Apart from this, are issues of power and the difficulties of how workers representing ‘others’ (users, communities etc) and power relations between the worker and the employing organisation.

2.6.4 Targeting Resources to marginalised voices

It would therefore appear that even in the consultation process, distressed South Asian women are excluded. Whilst it is important to work with existing South Asian organisations, it is equally important to be inclusive and ensure that spaces were created to hear the voices of South Asian women on the margins or 'outside' their communities. As one of the commissioners said,

“.....by using different tools for different people,..... the way you'd access South Asian gay and lesbian people would be different from accessing older Asian people.”

2.6.5 The important role of Refuges

The necessity to access South Asian women, especially those experiencing suicidal feelings and wanting help with self-harm is important, and given all the constraints mentioned above, it could be argued that focussing or targeting resources to hearing these voices is especially urgent. At the very least, there is the need to ensure that women-only spaces are created to consult with South Asian women. More specifically, from the survivor accounts, it can be seen that there are strong links between attempted suicide / self-harm and wider systemic issues, particularly domestic violence. However, not one single senior manager referred to any partnership arrangements with refuges. The findings from this study would strongly support the need for this to be rectified and to recognise the hitherto unrecognised mental health service that refuges are offering.

Indicators of Good Practice

- Awareness of the limitations of 'cultural' information
- Engagement with the complexities of communities, particularly in relation to inequalities based on gender, class and other marginalised groups
- Targeting resources to marginalised voices, especially South Asian women
- Recognising the pivotal role of women's refuges in this area of work

2.7 The “whiteness” of current service user and carer groups

Whereas consultations with communities (despite the drawbacks mentioned above and the potential serious consequences of this for South Asian women), partnership arrangements with South Asian service users (groups) or carers (groups) were even more patchy.

“We haven’t had those discussions” [re: South Asian women service users and carers]

“With extreme difficulty.”

“We don’t really at the moment, being frank...service user groups are white men usually, so don’t represent a range of users of services or carers.”

It can therefore be concluded that where consultations with service users and carers take place, the views of South Asian people in general and South Asian women in particular are not currently being engaged with. As the last comment demonstrates (and the others imply) existing service groups are dominated by whiteness and maleness, thus reflecting within service user groups the dominant structures at a societal level. One way in which current service user groups will continue to stay white and male is if their membership is not challenged by those who consult or work in partnership with them. The argument is frequently put that service users have enough problems and issues of their own and it is not fair to challenge them on their organisations. This may be acceptable if alternative methods of involving South Asian women and other marginalised groups as service users/carers were implemented – but there was no evidence of this, even where there seemed to be a genuine interest in involving South Asian service users or carers.

2.7.1 Champions

The notion of the need for ‘champions’ within a service was articulated as a strategy for changing practice in favour of South Asian women. This has resonance with the often unspoken expectations of Black workers (and other marginalised workers) within services and of advocacy groups. Champions are seen as committed individuals who advocate strongly and mobilise politically for particular constituencies or stake holders. Frequently, there is very little understanding of the power dynamics involved in championing. It could be argued that people normally ‘champion’ a cause when their life experiences conjoin with the cause. Following this, it is likely that a ‘champion’ for South Asian women would probably be another South Asian woman. Given that mental health services still reflect dominant hierarchies based on race, class and gender, it is unlikely for such a champion to be part of the senior management or decision making body as to how available resources are spent. It could also be argued that people who make it to the top need to fit into the prevailing culture based on existing privilege, so that any sense of a more radical politics may have to be ‘watered’ down for survival. Hence ‘champions’ for marginalised groups are unlikely to be found at higher echelons of management. ‘Champions’ are more likely to be basic grade workers with no power, yet charged with the responsibility of being major catalysts of change - a responsibility seemingly not shared by senior managers.

2.7.2 'Hearing voices' – responding to the loudest

Linked to the discussion about champions is the issue of responding to the loudest voices. The majority of managers acknowledged that they listen to the loudest voices, and in this sense they are reactive rather than proactive.

Most senior managers interviewed felt that service user groups are or would be an influential focus for changes in service delivery. Within this, it was acknowledged that the voices that would be listened to would be the loudest ones. Traditionally, such groups have been dominated by white men (see whiteness of current service user groups above) and therefore it is likely that their voices are more likely to be heard, to the exclusion of others.

“They [South Asian women] don’t have the same voice, can’t lobby in the same way because the services have to look at a lot of different factors.”

What was striking in many of the interviews was that many senior managers seemed to accept not hearing the voices of South Asian women, despite being aware of the increased isolation of South Asian women. For the most part, no special efforts were being made to include South Asian service users or carers in either formal or informal planning mechanisms for services. Some of this can justifiably be explained by the newness of many services and commissioning arrangements, but even for example, where workers were to be appointed to work with service users or carers or were already in post, there was no guarantee that this would include the perspectives of South Asian women.

The rationale given for this situation was the lack of resources. Whereas lack of resources is the context of mental health services, it equally needs to be acknowledged that the needs of marginalised and ‘invisible’ people need to be prioritised. Indeed within scarce resources, it is argued here that first priority should be given to ‘hearing’ and acting upon currently unheard voices. Instead it would appear that the easier option of responding to the loudest is taken in the name of service user consultation and involvement.

2.7.3 Embedded structures

Linked to the point above, is the need for embedded structures. Plainly consultations either with community groups, service user or carer groups (ensuring ‘different’ voices are attended to) are tokenistic unless the views from the consultations are taken seriously to influence change. It needs to be recognised that although the responsibility for culturally sensitive services is a collective one, greater responsibility (and power) lies with senior managers to commission, develop, implement, monitor, evaluate etc services. This does not of course preclude working in partnership with others. However, for partnerships to feel real and have tangible outcomes, particularly with black communities or service user groups, these processes need to be part of the organisational structure to ensure that the work carried out is fed into

and is a central part of decision making.

“There are frameworks in place, but we still have the difficulty of engagement, also one always worries about tokenism.”

Despite the difficulties of consultation, especially with South Asian women, in Trafford and Manchester, organisational structures were mentioned into which consultation processes fed in. The key ones were the Local Implementation Group (Trafford) and the Race and Health Forum at Central Manchester Primary Care Trust.

2.7.4 Potential of exploitation and appropriation of Service user groups/carer groups

As a principle of good practice, nobody could argue with the view that involving/consulting service users and carers in the delivery of services is important and necessary. However, there is a potential danger that managers, including senior managers who are paid to develop and respond to mental health needs could jettison their responsibilities disproportionately onto service users and carers – without financial recompense or the power. Senior managers still have all the choices about how resources are allocated and how services are developed. This is not an ‘equal’ partnership at all. In effect, these groups can be perceived as providing the ‘champions’ and making the loudest noises in an attempt to make services more responsive to their needs. This leaves the core of the mental health organisations free to carry on in the way that they always have whilst appearing to do something to involve service users and carers.

What started out as allied to empowerment has the potential to be appropriated by the statutory sector in a way which does little to shift or redistribute the power imbalance between providers, funders and service users and carers.

2.7.5 Consultation burn out

There was a concern expressed by some that there was ‘consultation burn out’.

“We ought to know [the issues] by now.”

“There is a danger that black communities could be consulted to death.”

The implication here is that organisations need to learn the lessons from their consultations. This is a view that was also expressed by Black communities in Greater Manchester around issues of substance misuse (Chantler et al, 1998). There will be many common features that could be applied across a range of service developments and across a range of Black communities. For example, one would expect a diverse range of Black communities to say

that services on the whole are not accessible, that staffing does not reflect the demographic composition of the area, that they do not feel understood or supported by mainstream agencies, that they do not always understand how services work, that there is a level of mistrust and suspicion associated with the 'establishment' etc. So why the constant need to consult? One conclusion that could be drawn is that it is too difficult and challenging for 'caring' organisations to hear this kind of response. Instead, a diversion is then deployed to differentiate almost obsessively the differences between say Pakistani and Bangladeshi communities. A more fruitful way forward would be to accept the general criticisms and start working on the services own structures, methods of work, staffing, power relations etc rather than to focus attention solely on Black communities. The cry that there is not enough information also masks an apparent unwillingness to learn, understand and act from previous consultations.

Indicators of Good Practice

- Participation of South Asian service users and carers in partnership arrangements, particularly women
- Ensuring that consultation feeds into decision making structures
- Guarding against over use of 'community' groups in consultations
- Examining own structures, policies and practices and taking action to ensure that these are inclusive of South Asian women

2.8 Mental Health Services and South Asian women

Central to the way in which services are commissioned and provided are the understandings that are brought to bear in relation to South Asian women and mental distress, specifically attempted suicide and self-harm. Making explicit such understandings is clearly important both for managers as well as workers within the mental health field.

2.8.1 Senior managers' understandings (South Asian women/mental distress)

There were a range of understandings, which can be broadly categorised into those managers favouring 'cultural' factors and those that also included structural factors.

"I think sometimes particular issues around stress in families – family culture, around violence from a partner, immigration status. For some young Asian women it could be some expectations put on them by their family, tensions between wanting to retain family culture versus being in Britain and the sheer racism they experience."

“I think broadly there are issues of culture and being within a dual culture.....but services don’t understand the needs of young Asian women.....expectations of family, when [they’re] in trouble, there’s very little to support [them].

“Lack of understanding of their problems and a lack of provision of appropriate services... People living in different culture and there are dichotomies and contradictions for them whether it’s about perceived freedom, different expectations, wanting something different”.

Whereas it is encouraging and important that senior managers own responsibility of inappropriateness of services and see this as a possible contributory factor to suicide and self-harm, the comments about culture seem inadequate when juxtaposed with the survivors’ accounts of domestic violence, sexual abuse, immigration controls, poverty, and lack of educational opportunities. Indeed, it could be argued firstly, that the comments about culture help to camouflage and sanitise the brutality of women’s lived experiences, and secondly, that in this context culture – or rather ‘Asian culture’ could be seen as deficient and problematic. Third, the focus on culture, i.e. on ‘race’ becomes privileged at the expense of the interconnections between ‘race’/gender/ class etc. It is therefore crucial that cultural understandings are located within the wider context of racism, sexism, class and other oppressions.

Indicators of Good Practice

- Policy planning and service delivery which address the links between systemic issues and mental distress

2.8.2 Principal ways of organising mental health services

Within this study, 3 principal ways of providing services to South Asian women at risk of suicide/self-harm were cited by senior managers. These were:

- generic, mainstream mental health services
- specialist South Asian mental health projects
- South Asian community groups.

2.8.3 Generic services – how inclusive are they?

“We haven’t done anything that’s targeted at South Asian women particularly, but within general provision such as proper care planning and management, daytime opportunities in

it's widest sense, crisis services that are responsive, assertive outreach. So suicide prevention is based on these with an eye to reduction."

"I've got a sense that we would say that dealing with issues of suicide among South Asian women would be handled within general priorities rather than separately.....I haven't heard anyone from Salford or Trafford raise issues regarding south Asian women."

"I don't think we have a carefully thought through plan in terms of South Asian women...at a strategic level there hasn't been considered planning and discussion around South Asian women and there needs to be."

"White women can link into the service and systems better and the system understands them better. Services are there to meet the needs of the mainstream and if you fall outside of that it's hard to have your needs met."

From the senior managers' own admissions, it can be seen that very little consideration has been given to meeting the needs of South Asian women within generic or mainstream services. Significantly, the voluntary sector organisation interviewed for this part of the study was able to demonstrate examples of good practice in relation to South Asian women within its generic service.

However, for the most part, South Asian women are expected to fit in with the services on offer described as:

"Undoubtedly white dominated service so the relatively small number of South Asian women are significantly disadvantaged."

".....statutory services which are very white English"

"We try to provide appropriate services for identified needs and I think we don't identify the needs [of South Asian women] properly."

"If we look at day services for example, I would imagine that Black women are under represented in terms of their attendance. Some practitioners work hard to make sure that doesn't happen....but changing the culture of day services is a complicated thing."

One senior manager also felt the consequences of gaps in primary care services could lead to an escalation of the 'tariff' for South Asian women – in that they are entering secondary services where white people and English speaking Asian people would not be.

"We can do quite well in secondary care – if we delivered more appropriate services at community level, maybe we wouldn't be needing to admit them [South Asian women]"

2.8.3.1 'Race', Gender and Mental Health

In the consideration of the intersections of 'race', gender and mental health, it is important to recognise the inequalities in the access to and treatment of Black people within the mental health system (e.g. Ahmad, 1992; Fernando, 1991; Littlewood & Lipsedge, 1982), but also to acknowledge that many of the concerns highlighted in these works are not gender specific, and therefore do not pay enough attention to the position and treatment of Black women (Burman et al, 1998).

As one of the senior managers put it:

"There's been a lot of interest in African-Caribbean young men, but there hasn't been the same dialogue about South Asian women – they're not visible or their needs are not being articulated, it's not getting the attention"

Equally, there is also a substantial body of work focusing on women and mental health which also excludes the specific and distinct experiences of Black women (Aitken, 1996). The conclusion that can be drawn from this is that when issues of 'race' are considered, these tend to exclude issues of gender, and when issues of gender are considered, they tend to exclude issues of 'race', as illustrated in the following:

"I'm not sure that it [South Asian women] would be the highest priority. We have major problems to do with the extent services are appropriate to women as a whole, major problems with the extent that services are appropriate to ethnic minority groups, major problems as to whether services are appropriately responsive to the needs of the individual – these are significantly higher concerns than services appropriate to South Asian women. We face bigger issues, part of my reservation is to do with numbers."

It is to the issue of 'demographics' that attention is turned to next.

2.8.3.2 The numbers game – can we justify resources?

The small population of South Asian people, particularly in Salford, was the main argument put forward for not developing services for South Asian women. There will no doubt be areas within Manchester and Trafford where the smallness of numbers is likely to be seen as problematic in the delivery of accessible and sensitive services. There are however several reasons why low numbers are inadequate to justify lack of resources of specific services. First, people's entitlement is regardless of how small a group they form - as they are tax payers/council tax payers. It would never be suggested for example, that Asian women don't need to pay taxes/community taxes as mental health services are inaccessible to them!. Second, precisely because of the low numbers and hence increased sense of isolation, there is a greater urgency for services in "white" areas to be proactive in the development of services to South Asian women. Third, the argument that one need only needs to care or to provide a service

when there are large numbers of a particular group is a strange contradiction given the espoused values of health and social care work emphasising respect, dignity, choice, autonomy, and individual packages of care.

While it is often argued that providing a service for small numbers is not cost effective, and that it does not fit into the best value agenda, there must surely be more creative ways of managing services other than ignoring the needs of South Asian women. Key to a change agenda would be to develop a new way of conceptualising the issues.

2.8.3.3 Thinking differently

The exclusion of South Asian women in the consideration of mental health services as evidenced above and the need to justify spending resources on this group requires elaboration. The current thinking shows a lack of understanding of the intersections between the 'race', gender, and class positions and a preference for modes of thinking which compartmentalise differences into discrete entities. If commissioners and providers could start by looking at the needs of South Asian women, this would have ripple effects into improving services for other women too. So for example, the need for single sex accommodation/provision maybe seen as particularly relevant for South Asian women but would also have the benefit of making services less intimidating and more accessible to a whole range of other women. At the very least it would offer choice about the what kind of services women want. Similar benefits would accrue for example, from having information about services on audio/video tapes in English and other languages or choices about whether one wanted a male or female worker, as well as appropriate childcare support. Hence the question of a shortage of resources or fears that resources are being disproportionately directed towards a very small number of people is also challenged by this approach. Second, thinking about interconnections and intersections helps us to look at issues of sameness and differences rather than focussing solely on 'otherness'. The danger, as always, remains that in looking at sameness as the evidence in this study suggests, the differences are ignored, marginalised or feared. Staying with sameness (or "universal") whilst excluding differences provides a safe comfort zone for service providers and commissioners and a failure to act on their responsibilities to provide a service to all the communities.

Indicators of Good Practice

- Policies and practice which engage with the intersections between 'race', class, gender and other oppressions
- Service provision that addresses the specificities of the needs of South Asian women as well as the connections with other women
- Equity in service provision regardless of smallness of demographic population

2.8.4 Specialist South Asian Mental Health Services

Manchester and Trafford both have access to specialist South Asian mental health services. Most of these are commissioned from voluntary sector organisations, but one is part of the mainstream statutory sector. Having access to such provisions were cited as examples of good practice. Whilst it is argued here that specialist South Asian mental health projects are an essential component of “culturally sensitive” services to South Asian people, this is not a blanket endorsement of such projects. Firstly, within the context of South Asian women, attempted suicide and self-harm, any such project needs to be woman-centred and needs to have the competencies required to work with the complex issues of attempted suicide and self-harm. Secondly, the relationship between the projects and the statutory sector need to be clearly understood.

2.8.4.1 Disproportionate distribution of responsibilities

Despite contacting the local authority at directorate level and asking to conduct the interview with a senior manager, we were referred to another senior manager who advised us to contact a South Asian mental health project from whom the local authority contracted services. Similarly, when we contacted the community mental health team in this area, we were similarly directed to the same project. What this illustrates is that the responsibility to provide a wide range of mental health services to Asian women is perceived to lie with the Asian mental health project. Whilst on the one hand it could be argued that the statutory sector has endeavoured through their contracting arrangements to provide a service to South Asian women, it is clearly unrealistic to expect that a small voluntary organisation can offer the full range of services required to work across the mental health field. This South Asian project was cited as being involved in the following activities: community based mental health services, secondary care services, training, monitoring and evaluation, and as members of the reference group and Local Implementation Group.

Whereas on the one hand this is seen as working in partnership, the inequalities in power, the disproportionate distribution of responsibilities and skewed resources also need to be acknowledged. The workers on the project seemed very overworked and this is hardly surprising given the range of tasks expected of them. Yet in the particular context of suicide and self-harm, these workers (mostly qualified social workers) did not feel they had the necessary skills to work with these issues and would refer them back to mainstream services, with whom they would co-work where feasible. The limits or boundaries therefore need to be clearly drawn for the protection of both staff and users of the organisation. Similar considerations apply equally well to the statutory sector specialist service.

At the same time, commissioning organisations need to ensure that the rest of their services are also able to provide a service to South Asian women.

“Having specialist services for South Asian women, but also we need to think carefully about the rest of the services so you don’t [only] create pools of accessibility”

“Specialist services act as a voice but that doesn’t mean that’s the only contact otherwise you’re perpetuating the discrimination, isolation etc.”

It is plainly not a satisfactory arrangement to ‘dump’ responsibility for the provision of mental health services on to a relatively small South Asian organisation whilst mainstream organisations make little or no changes either to their own services or to the services they commission. Secondly, the funding arrangements make it difficult for specialist services to challenge the hand that feeds it, which means that they are in danger of reproducing some of the very structures that they originally sought to challenge.

It needs to be stressed that there is obviously a need for South Asian organisations but this does not absolve the statutory sector from its continuing responsibilities to ensure that their own mental health services are accessible. South Asian projects can and do provide a safe haven, but when South Asian women need to be referred on from these, where are they to be referred to if they are perceived to be the sole agency with responsibilities to this service user group?

2.8.4.2 Choice

One of the temptations when there is a specialist service available, is to refer all South Asian service users to it. It is clearly important to check preferences out with individual service users and to acknowledge that not all South Asian people would want to be helped by a South Asian organisation or by South Asian workers in mainstream organisations. The reasons for this can be complex and may include responses based on internalised racism, fears that information will not be kept confidential and fears that ‘taboo’ subjects such as attempted suicide/self harm will not readily be ‘heard’. However, all these factors could equally well apply to white services, but may not be so visible. In any case, it is vitally important that choice of service for South Asian women is not restricted purely to South Asian services. The implications of this is that mainstream services also need to provide an accessible and appropriate service. Far too frequently the debates are framed in an either/or framework rather than allowing for both mainstream and specialist services to be equally accessible to South Asian women.

Indicators of Good Practice

- Specialist South Asian mental health provision
- Mainstream provision to also be accessible to South Asian women
- Workers in both sectors to have competencies in working with both suicide/self-

- harm and 'race', gender, and class positionings
- Constructive engagement with the power dynamics between mainstream and specialist services to improve partnership arrangements

2.8.5 South Asian Community Groups and Attempted suicide/self-harm

Particularly in Manchester, funding South Asian community groups was seen as an important way to prevent suicide. However, there is a tension here between the funding of generic South Asian women's community groups and the specificity of dealing with issues of attempted suicide and self-harm.

KC: "How do you propose to implement the National Service Framework standard to do with the prevention of suicide in relation to South Asian women?"

Senior manager's response:

"Can't tell you in detail. One hopes, assumes that workers [from the community groups] know how to contact mainstream services and develop good links – there are local authority and health authority agreements in place, so presumably they should link into mainstream services. As low intensity community groups they're meant to provide support and be preventative rather than crisis. I think that's good because it's about people having access to help and advice at as early a stage as possible and mainstream services kick in after that."

Whereas general benefits maybe gained through support groups, it is not clear what happens in terms of support to South Asian women who are experiencing suicidal feelings and / or are self harming and need help with this particular aspect of their lives. The response given above is worrying on several counts:

a) There are limitations deriving not only from the generic nature of groups (rather than a community based specific suicide/self harm or counselling service), but also how accessible they would really be within communities. As attempted suicide/self-harm is likely to be a response to oppression based on racialised, gendered, class etc experiences including sexual abuse, domestic violence, racial harassment, and immigration, some of these will be issues that 'traditional' community groups may have difficulty in working with as it challenges their own assumptions about community and what it should be, particularly in the context of a racist (and sexist) environment. It would appear that some community organisations are more willing to acknowledge the racist (rather than the sexist) contexts within which they are operating (see worker discussions). So the funding of generic groups without an appreciation of the structural complexities and exclusions of their contexts of functioning is a dangerous policy, particularly for the most vulnerable and marginalised.

b) There is also an assumption that workers within the community groups 'know' mainstream services and how to access them. This seems a big assumption to make given the complexities of mental health provision, particularly at the moment when services are re-organising and everything is changing (and the difficulties we have had in trying to make sense of services).

c) if the main support available to South Asian women who are distressed is via mainstream services, it begs the question of how accessible and appropriate these services are.

"I suppose all the groups that are funded are an attempt to supplement statutory provision which is very white English."

It would therefore appear that just at the point where South Asian women maybe at their most vulnerable, they are faced with a very 'white' service. The implication here is that the service would not be appropriate or sensitive. Furthermore, given the generic nature of the funded community groups and their exclusions as discussed above, there does not appear to be a safe space for South Asian women who are at risk of suicide or want help with self-harming. Hence we come back full circle to mainstream services.

Indicators of Good Practice

- Recognition of limitations of community based groups for suicide and self-harm
- Dedicated services for suicide and self-harm for South Asian women
- Gender sensitive, anti-racist services (mainstream and specialist)
- Improved links and referral processes between community groups and mainstream services

2.9 The Way Forward

Apart from increased resources, 2 additional suggestions were made by the majority of senior managers in this study for advancing work in the area of attempted suicide/self-harm and South Asian women within mainstream services. These were:

- Recruitment of South Asian workers
- Staff and Management Development

2.9.1 Recruitment of South Asian Workers

The recruitment of Black workers is a frequently cited strategy for making services more

accessible to Black communities and indeed is often seen as a quantifiable and appropriate measurement of an organisation's ability to develop and deliver accessible and sensitive services. Policies to retain Black staff are also vital as are issues of non-marginalisation.

Whilst it is plainly important that Black workers are part of organisational life, assumptions cannot be made about the homogeneity of Black workers in terms of their politics and therefore the perspectives they bring to bear on their work. The recruitment of large numbers of African-Caribbean women into the health service at the end of the second world war has not resulted in the National Health Service embracing a black feminist perspective or agenda! Clearly linked to this is also the position of black women within the hierarchy. It is patently unfair for other workers and senior managers to abdicate the responsibility for race equality or accessible and sensitive services onto black workers.

2.9.1.1 Theoretical models

A further issue is to do with the conceptual frameworks and theoretical models that are used in service delivery. If these remain unchanged, then the question of what difference a worker of a different colour or culture, gender etc makes has to be asked (Burman, 2000; Mercer, 1986). Given that training in the UK for mental health professionals remains eurocentric, (and that this will include the training experiences of Black workers as well), the main hope for delivering appropriate and relevant services lies in workers (black and white) and managers developing the kind of politics and conceptual frameworks that are genuinely inclusive, and prioritising change agendas that are properly resourced and supported to challenge existing dominant ideologies and hierarchies. It is frequently mistakenly assumed that theoretical models and conceptual frameworks are 'objective' and politics free and therefore applicable universally. At the same time when feminists, for example, have challenged the sexist, racist, classist, heterosexist tenets of such work, they have been accused of being too political or too ideological. Such critics have failed to recognise or acknowledge the politics or ideologies inherent within their own frameworks and until there is a genuine dialogue generating different understandings leading to tangible outcomes, it is hard to see how the recruitment of black workers in itself will effect the desired changes. Indeed, within this study, in interviews/discussions with some South Asian and other Black staff, there were a few times when these workers expressed views which could be considered to be stereotypical. This is not said punitively or to imply that all South Asian/Black workers 'should' know better. Given the pressure for all of us to conform to the 'norm' it is no more surprising for black workers to get it 'wrong' than white workers.

2.9.2 Staff and Management Development

"I think very few managers have that level of understanding at the moment. I think it's possible to be a senior manager and exist within a white, middle class enclave and not be

part of a multi-cultural city.”

“A better understanding of mental health issues for Asian women and cultural understanding, as well as information about suicide and self-harm”.

“We need access to support around developing services and how to operationalise it”.

“I think there’s a lack of training around all sorts of issues around ethnicity and culture, so [people are] afraid to ask in case of appearing racist, but it probably leads to an inadequate assessment”.

“Training needs to be there...it’s very difficult, staff feel swamped with the amount of change they have to take on board, social workers are aware of the deficiencies, but it’s not easy for them to do anything about it, because of racism within services. Being aware doesn’t mean you can change it... No matter how many groups we fund, mainstream services have to take it on too. We need a long-term investment in the work force”.

So whereas on the one hand, training is seen as important, as was stated, being aware does not change things. It could be argued that training is a necessary first step – however the experiences of Race Awareness Training (Sivanandan 1985) and multi-culturalism are not particularly encouraging – what have people done with their new found awareness?. Issues around who is doing the training, and what perspectives they are privileging also need to be taken into account. As is also implied in one of the statements above, any training is going to have to grapple with issues of fear and anxiety and the consequent defensiveness that is likely to be displayed. Further, there are organisations who see one or two day workshops around race as the key intervention required to deal with race equality. Training is not going to work unless it is part of a proactive wider strategy to counter organisational and institutional structures which discriminate and oppress marginalised groups.

Suicide and self-harm in South Asian women is not only about ‘race’, nor only gender but about the complex intersections between their meanings, experiences and representations in the broader context of social inequality.

Indicators of Good Practice

- Developing a woman-centred, anti-racist workforce
- Challenging eurocentric, gender and class biases of existing models of mental health work
- Management development program to commission, develop and operationalise suicide and self-harm services in relation to South Asian women

2.10 Summary

The impact of the contract culture emerged as an important issue in the senior manager interviews, specifically the relationship between commissioners and providers where each sees the other as responsible for ensuring appropriate services for South Asian women in distress. The threats to the autonomy of the voluntary sector was also discussed, especially its fragmentation through competition. The traditional strengths of the voluntary sector, particularly campaigning work and radical practice are also jeopardised with tightly controlled contracts replicating funders' priorities both in terms of concentrating on 'medical' categorisation of service users and the consequent emphasis on service delivery. The need for evidence based practice was also explored, drawing attention to the fact that there is no national (or local) information about mortality rates from suicide and undetermined injury by ethnicity. Therefore, the need to consider alternative forms of evidence as valid, such as this report, and the Newham study on attempted suicide and self-harm - South Asian young women is crucial (Yazdani, 1998).

Turning to partnership working, the evidence demonstrates partnership arrangements are more firmly secured with South Asian community groups compared with South Asian service users or carers. However, within community consultations, the current focus appears to be on consulting with the more dominant rather than the more vulnerable or marginalised. It is strongly argued that consultations should be targeted at listening to the voices of South Asian women in recognition of the diversity within communities based on power relations. Hence women-only spaces are important as is the central role of South Asian women's refuges – a hitherto unrecognised mental health service.

The 'whiteness' and 'maleness' of service user groups as the loudest voice and the consequent silencing of women's voices, especially South Asian women needs to be rectified. Several measures are either in place or coming on line to widen the participation of service users and carers, for example Service User or Carer development worker posts. However, no evidence was offered as to how this would include South Asian people. It also needs to be recognised that 'champions' such as these as well others within services (e.g. Black workers), are themselves often marginalised and therefore the potential for change is limited if it is seen as being solely their responsibility. The need for 'embedded structures' is therefore crucial. Lessons of tokenism and marginalisation, particularly from the experiences of Black workers are important to learn from, if the service user and carer groups are not to become exploited and appropriated in the same way.

Senior managers' understanding of the issues contributing to South Asian women attempting suicide and self-harm needs to be enhanced in three key ways. It is argued firstly, that the focus on 'cultural' issues firstly help to camouflage and sanitise the brutality of women's lived experiences and secondly, in this context culture – or rather 'Asian culture' could be seen as deficient and problematic. Third, the focus on culture, i.e. on 'race' becomes privileged at the expense of gender and the interconnections between 'race'/gender/ class etc. It is therefore

crucial that cultural understandings are located within the wider and intersecting contexts of racism, sexism, and class – as is amply illustrated by the survivors' accounts.

There are three principal ways in which mental health services are offered to South Asian women. These are through: 'universal' or generic, mainstream services, specialist South Asian mental health services and through South Asian community groups.

The evidence clearly illustrates that universal provision has not taken into consideration the needs of south Asian women. There appears to be a reluctance to focus specifically on South Asian women, either because of the small percentage of South Asian people in certain localities or because it was felt that mental health services needed improving for everyone – not just South Asian women. However, the universalist framework operates from a 'colour blind' perspective and the exclusion of South Asian women in the consideration of mental health services as evidenced above, and the need to justify spending resources on this group requires challenging. Central to this, is the need for a re-conceptualising of the issues with an understanding of the intersections between 'race', gender, and class. This new frame of reference could provide opportunities to adopt a more radical approach by starting with the needs of South Asian women, with ripple effects into improving services for other women too (e.g. single sex accommodation, audio/visual information about services, choice of male/female worker, home-based or centre-based services and appropriate child support).

Although specialist south Asian mental health projects are to be encouraged, in the context of suicide and self-harm it is vital that they are woman-centred and that the workers have the requires competencies to work effectively with issues of suicide and self-harm. The relationship between such services and funders currently indicates that they are a tokenistic response. Whilst on the whole senior managers recognise that their own services need to be more sensitive and relevant, little evidence was offered as to how this was to happen. In relation to suicide and self-harm, workers from specialist projects felt they would refer back to mainstream services and co-work where feasible. The funding of generic south Asian community groups whilst providing "low intensity" support do not offer support in times of crises and again women in distress would be referred back to mainstream agencies. Hence the circularity of this process cannot be ignored and it is essential that mainstream services act to ensure that their services are more accessible.

Two key strategies were suggested for improving mainstream services: increasing the number of South Asian woman workers and staff and management training. Apart from the issues of tokenism and marginalisation already discussed, consideration also has to be given to the conceptual frameworks and theoretical models that are used in service delivery. If these remain unchanged, then the question of what difference a worker of a different colour or culture, or gender makes has to be asked. The assumption that theoretical models are politics-free and therefore universally applicable is clearly questionable. In respect of training, one or two day workshops around 'race' are not adequate as the key intervention to deal with race equality. Training is not going to work unless it is part of a proactive wider strategy to counter

organisational and institutional structures which discriminate and oppress marginalised groups. Suicide and self-harm poses complex issues for training that call for practices that connect anti-racist and gender-sensitive understandings as well as clinical management of distress and abuse.

3 WORKER DISCUSSIONS

The major resource of any 'helping' agency is its staff. It is staff who put policies into practice, form teams and come into direct contact with the public. If gender and race equality policies are to be effectively implemented, particularly attempted suicide and self-harm in relation to South Asian women, then the development of staff's skills, knowledge and engagement with the issues is crucial. Staff can only begin to practice differently, if they understand the need for change and are helped to develop the skills and knowledge to bring it about. This strand of the research was therefore staff-based and involved conducting group discussions or interviews with a range of workers in the mental health field.

3.1 Workers in the mental health field

A broad definition of 'workers' was used in an attempt to include in the research a range of professional and work settings in the mental health field in Manchester, Salford and Trafford. This included both the statutory and the voluntary sector. The following groups of workers were contacted: social workers, community psychiatric nurses, GPs, consultant psychiatrists, nursing staff on psychiatric wards, accident and emergency staff, mental health support workers, teachers, health visitors, counsellors, specialist suicide/self harm workers, refuge workers, link workers, and specialist South Asian mental health workers.

(A list of agencies contacted is in Appendix 2)

3.2 Difficulties in Accessing Workers

The original research design had aimed to interview groups of workers. As contact was made with the agencies, it became clear that this was not always going to be possible. For some organisations contacted, there appeared to be some ambivalence around the issues. Some managers were unsure of what their teams could contribute as they had not had many dealings with South Asian women who had attempted suicide or self-harmed. Others felt that it would be better to conduct discussions with specialist South Asian mental health services. In other instances, although group discussions had been set up, they turned out to be individual interviews due to other pressures of work.

3.3 Group discussions/interviews

The group discussions or interviews were facilitated either jointly or singly (as appropriate) by Janet Batsleer and myself. The discussions sought to establish workers views on the following:

- Current perceptions and understandings of suicide/self harm issues in relation to South Asian women
- Service delivery issues to this group of service users, including examples of good practice and gaps in services
- Perceptions of their support needs including training and development needs.

(The interview schedule is in Appendix 4)

A total of 18 discussions were held covering a wide range of work settings.

3.4 Confidentiality arrangements

Workers were assured that their anonymity would be protected. This was especially important to encourage honest and open dialogue surrounding the contentious issues of 'race', gender and mental health. Workers were also offered notes of the discussion at the end of the interview.

3.5 Introduction

The evidence from the worker discussions is explored in the following ways. First, general understanding and attitudes about attempted suicide and self-harm are discussed. Second, the often hidden issue of 'race anxiety' is briefly touched on with a reminder of the need to frame this discourse within its proper context. Third, the factors seen as contributing to South Asian women attempting suicide and self-harm are considered. The analysis then moves on to consider fourthly, the inter-relationships between 'race', culture, gender and mental distress. Following on from this, fifthly, three key approaches to working with South Asian women are identified and analysed: the 'colour blind' approach, the 'gender-blind' approach and 'matching'. Sixth, it is urged that proper consideration be given to the support and clinical supervision of workers involved in this complex area of work.

3.6 Current perceptions of suicide/self-harm

The following sections summarises practitioners current understandings of (attempted) suicide and self-harm and the differences between attempted suicide and self harm. Issues around lack of understanding and de-sensitisation from the emotional distress expressed through suicide attempts and self-harm are also discussed.

3.6.1 Self-harm

There appeared to be a common understanding of what self-harm behaviour was and the

meanings that were ascribed to this. These were largely seen as actions that were harmful, for example cutting, hitting, banging head against the wall, and burning. Others also saw overdosing as part of self-harming behaviour. No specific methods was identified as being particular to South Asian women. Within the majority of discussions, self harm seemed to be understood within a framework that excluded substance misuse and eating 'disorders'- however the survivor accounts illustrate otherwise. There was also a shared understanding that self-harm was a way of dealing with difficult and painful emotional issues by diverting attention away from the emotional to the physical to provide a temporary sense of relief and well-being.

Self-harm as a survival mechanism, as an important coping mechanism and potential protective factor against suicide is now a better established understanding in the (feminist) literature on self-harm (e.g. Spandler, 1996, Maris, 1971).

3.6.2 Suicidal intent

Intention to kill one self was seen as a major difference between self-harm and attempted suicide. Hence although self-harm can act as a way of preventing suicide, the picture is more complex and a clear distinction cannot always be made between self-harm and suicidal feelings and actions. There is sometimes an ambivalence for people who self-harm about whether or not the self-harming leads to death. This emerged in the survivor accounts as well as in (a minority of) worker discussions.

“ I frame self-harm as survival, whatever the method - but suicidal people are working with hopelessness and despair. The two do overlap, it's not particularly about the methods, but the emotional territory”.

It is also important to note that people who have previously harmed themselves are considered to be at relatively high risk of suicide (National Service Framework for Mental Health, 1999).

3.6.3 Lack of understanding and De-sensitisation

Despite the feminist literature on attempted suicide and self-harm and various studies that give “voice” to survivors, (Arnold, 1994; Pembroke, 1994; Spandler, 1996), it is still the case that self-harming is not well understood. Several examples were given (in different interviews) of the way in which people who self-harm or with repeat suicide attempts are sometimes viewed as attention seekers and a drain on resources, because the injuries were self-inflicted.

“And I associate it [self-harm and attempted suicide] with attention seeking, a cry for help, not a serious intent to die.”

“.....people [those who self-harm] have been badly treated by the psychiatric system.”

“People can be very unsympathetic, for example in A&E with multiple repeat attenders and this can sometimes be generalised to everyone who self-harms. Some people don’t want to understand.”

“They don’t get much understanding, it’s hard for people to get their heads round it – they can’t put themselves in others shoes. Unless you’ve been there it’s hard to understand.”

“Some people find them [people who self-harm] very frustrating, irritating, manipulative and very confusing and they don’t really understand them.”

What emerges from the statements above, is that within the mental health field, there appears to be a lack of understanding and warmth displayed towards people who self harm and attempt suicide. This was also confirmed by the survivor accounts. Linked to the lack of understanding was a sense in which self-harming behaviour was sometimes judged as superficial, with workers becoming de-sensitised to the pain and the hurt. So for instance, in discussion with one group of workers, cutting of arms was seen as ‘superficial’, and in another group cutting or overdosing was seen as fairly standard behaviour which did not seem to warrant much attention compared to people who harmed themselves in more extreme ways such as mutilation of the genitals. Thus, a hierarchy seems to be in place with unspoken assumptions about who is deserving of care and help and who is not. Whereas at one point, cutting of arms might have been viewed as behaviour that needed attending to (physically and hopefully emotionally too), it would now appear that in some cases, the normalisation of cutting hinders workers from engaging with the underlying distress as they have become desensitised to it. So despite some increased understanding around issues of self-harm and attempted suicide, particularly in relation to emotional distress, the “hierarchy” also suggests that the physical manifestations of self-harming still tend to take priority over emotional understandings. The perverse, no doubt, unintended message that is also being sent to people who cut their arms is that to warrant attention, they will need to harm themselves more dramatically.

It would also appear that the level of understanding or warmth displayed is also linked to labels that individual service users may have, especially in psychiatric settings. Some workers interviewed in these work environments felt that understanding may be more forthcoming if self-harming was identified as part of a psychotic episode rather than seen as a personality disorder. It also needs to be noted that standard psychiatric responses to self-harmers is experienced by those who self-harm as deeply unsatisfactory (Arnold, 1995; Pembroke, 1994).

Indicators of Good Practice

- Recognising attempted suicide and self-harm as expressions of emotional distress

and an ability to engage with this

- Non-judgemental attitudes
- Working with the person rather than their psychiatric 'labels'

It is within this territory that we turn our attention to the specific issues of self-harm and attempted suicide in relation to South Asian women. Significant factors to consider as part of this, are the dynamics of 'race anxiety' and a reminder of the discursive framework within which these findings should be read.

3.6.4 "Race anxiety"

Some white workers expressed fears and anxieties that they may be perceived as racist. "Race anxiety" was displayed in different ways, indirectly from the process of setting up of group discussions, and more directly in the group discussions – where people had the confidence to acknowledge their anxieties about discussing issues of 'race', gender and mental health. These were most frequently framed within the 'political correctness' discourse whereby participants were acutely aware of how what they said may be interpreted. As one participant said, he did not want to appear to be a "colonial bastard". In order to be politically correct then, the safest option is either to remain silent about contentious issues or to bypass them by deflecting the issues onto South Asian workers and communities. A further form of non-engagement is linked to the presentation of issues. Many of the people contacted in this study did not see this as an issue as they had not had many dealings with South Asian women with suicide and self-harm issues and had therefore not really thought about it. The implications of all these factors, especially in connection to practice are discussed later. It is also probably no coincidence that there is a stark contrast in how the majority of white workers talked about the issues compared particularly to some south Asian women workers. Neither was "race anxiety" one sided - i.e. resting solely with white participants. Thus, some South Asian workers also expressed anxieties that in talking about issues of suicide/self-harm and south Asian women, this would further exacerbate the already damaging stereotypes of Asian cultures.

3.6.5 Framing the Discourse

Central to ensuring that these sets of anxieties are dampened, is to make space to discuss aspects of 'culture', including aspects of Asian culture that are frequently problematised (such as arranged marriages), and the perception that Asian cultures are more oppressive to women than white cultures. Clearly, such discussion needs to be paralleled by similar considerations of white 'culture' so that the commonality of the experiences of white women

and South Asian women based on a system of patriarchy, class, and heterosexuality are explicitly acknowledged and the racism inherent within this is also engaged with (see introductory chapter for a fuller discussion of the issues). These considerations of sameness and difference were therefore an explicit part of the discussions conducted with workers. It is within this context, that we present the following findings.

3.6.6 Contributory factors – South Asian women, attempted suicide and self-harm

Some workers (black and white) gave fuller explanations of factors contributing to South Asian women's distress. Factors mentioned as contributing to self-harm and attempted suicide included: wider social issues such as domestic violence, forced marriages (as opposed to arranged marriages), immigration, poverty, patriarchy, rape and sexual assault, housing difficulties, financial control exerted by families, racism and a lack of support systems. Within this, new migrants, especially younger women coming as brides who were unfamiliar with England and who did not speak English, were perceived as being more isolated – especially if their families were in the Indian sub-continent. These explanations are very closely matched by the survivors accounts. It is therefore crucial that both in understanding South Asian women's distress and in seeking to make services more sensitive, the wider social issues are addressed – both in the configuration of services and in the training and perspectives of workers in the field.

In comparing the experiences of distress of white women and South Asian women, it needs to be understood that even where factors are in common with white women (e.g. domestic violence, sexual abuse), access to services for Asian women is far more difficult, thus making isolation much more acute with fewer options to turn to.

Many workers (white and black) talked about the problems of living in two cultures and the difficulties encountered in negotiating the differences. Yet this analysis has several drawbacks. First, cultures are seen as essentialised, fixed and rigid rather than as dynamic and evolving. Second, implicit within this is the notion that it is only 'Asian' culture that is affected by the difference, so that examples of the way in which aspects of Asian culture impact on the rest of society are overlooked and minimised. These examples include a massive change in eating habits (the nation's favourite take-away is now chicken tikka massala), the long-standing fascination with eastern mysticism, "new-age" or alternative therapies which are often based on traditional South Asian healing (but not always recognised as such), for example, homeopathy, massage, aroma therapy, yoga and meditation. The importance of women-only space in South Asian cultures which has been used both for more restrictive practices, but also as an important site for resistance and liberation is also significant (Khan, 1999). Indeed, it could be argued that western feminists were slow in seeing this latter potential of women-only spaces. Third, and probably most important, what the 'culture clash' analysis does is to de-contextualise and to mask, ignore and perpetuate unequal power relations, and to intervene in ways which makes services inaccessible and insensitive to those who they may be trying to reach. More specifically, this approach fails to engage with or to acknowledge systemic and

structural issues such as sexual abuse, domestic violence, racism, immigration, and poverty which are very clearly articulated in the survivors' accounts.

The view was also expressed that South Asian women are emulating white women in relation to self-harm, (particularly cutting) and that these are not 'Asian' forms of demonstrating distress. The view that certain forms of distress are culturally specific in the context of increasing globalisation has been challenged by Littlewood (1995), especially in relation to eating disorders, also previously thought to be manifestations of distress 'belonging' to western women. Moreover, as the survivors' accounts in this study illustrate, South Asian women do self-harm. Self-harm in young Asian women is also evidenced in the Newham Asian Women's Project study of suicide and self-harm (Yazdani, 1998). It is crucial that stereotypes or mistaken cultural assumptions are not used to disguise modes of expressing distress that may appear unconventional to particular cultures. Aspects of culture and gender are now explored more fully to elucidate how the complex and multi-faceted layers can interplay to leave South Asian women vulnerable and unprotected.

3.6.7 'Race', Gender, Culture and Mental distress

".....also taboo word of mental health – they can't be very open about illness, especially women – they're seen as lazy, they don't have any sympathy and however much you try and educate, it hasn't made any difference. It's seen as an evil spirit. A lot of people won't take the recommended dosage and the family won't monitor the medication, then they go to the priest".

The quote above, from a worker, raises a number of pertinent issues, namely the relationship between mental health and taboo, community education, issues of gender, medication and the role of spirituality. These are now elaborated further to illustrate the complex ways in which these interconnect and the implications of these for South Asian women and distress.

3.6.7.1 Mental distress and Gender

Perceptions of mental well-being, particularly for (all) women have long been associated with traditional gender roles and expectations (Chesler, 1972; Penfold & Walker, 1984; Ussher, 1991). These perceptions are compounded for South Asian women within the mental health system as these gender roles will also be influenced by cultural stereotypes (e.g. of Asian women being quiet and passive). It is therefore not surprising that the dynamics of gender are also present in both the understandings of mental distress and the treatments chosen for South Asian women.

Indeed, it is important to note that many participants understanding of factors contributing to mental distress excluded issues linked directly to gender such as domestic violence, sexual

abuse and rape. It is also disappointing to note that that this exclusion is also present within the National Service Framework for Mental Health list of people at high risk of suicide. The list mentions unemployment, low income, poor housing and loss of a close relationship etc, but no mention of the additional specific issues that impact disproportionately on women's lives. Within that listing, the impact of racism and immigration does not figure either. This illustrates the ways in which mental health policies continue to exclude and omit the concerns of minorities, in this case women and Black people. Within this context, it is clear that exclusions of gender and 'race' in discourses about mental distress are not restricted to South Asian workers or communities.

Returning to this study, in one of the discussions, what became clear was the way in which understandings /meanings around gender, 'race' and mental distress were talked about. While in one group, the woman worker was explicit about possible factors leading to suicide/self-harm (sexual abuse, domestic violence, caring responsibilities, grief) the male workers cited 'difficult or unhappy' relationships and economic factors. In doing this, they were replicating the thinking and analysis offered at a wider level e.g. NSF. Words such as 'difficult or unhappy' sanitise, minimise and make invisible the depth of distress in women's lives.

Significantly, although the male workers had a good analysis of racism and gender (when it came to white women), they seemed reluctant to apply this analysis to South Asian women. For example, they claimed to have never come across a situation where a South Asian woman might need to leave home – while in contrast the woman worker was currently supporting two women where this might be an option (she asked for the telephone number for the refuge). So, there was a clear split along gender lines as to what was 'heard', and what was understood, which therefore had implications for the services offered to South Asian women. The male workers were implicitly endorsing traditional 'family' values, whereas the woman worker recognised and supported women experiencing oppression within families.

Many workers emphasised the importance of working with the family as opposed to focussing solely on individual work. However working with family groups (or individuals) is skilled and complex work. Unless the worker is fully aware of the power dynamics and the ease with which the (usually male) majority view prevails and is able to constructively challenge this, it is difficult to see how such an intervention would help South Asian women. At the same time it is important to recognise the differences in meaning attached to the notion of 'home' and 'family' and hence alternative formulations of patriarchy that also address the impact of racism on South Asian women's lives (Bhattacharjee, 1997).

In addition to the gendered view of mental distress discussed above, the myth of Asian families as all caring needs further consideration. The amount of support given to a distressed person by families and communities is also likely to be dependent on gender and marital status.

"A majority in Skultans⁶ study felt that taking care of a mentally afflicted man was the

family's responsibility, especially the wife's responsibility, but taking care of a mentally afflicted woman was her own family's responsibility, not the husband's responsibility."

(cited in Davar, 1999 : 128)

Hence, as noted by Davar, if a man is experiencing mental health problems it will be seen as his wife's responsibility to care for him. If a married woman is distressed, this level of support is unlikely to be found from her husband or his family as also confirmed in this study.

The role of women as carers is a powerful one in the majority of cultures, indeed it could be argued that 'care in the community' is a synonym for care by women. Thus what is important to bear in mind is the lack of support that is shown to women both in their caring roles, and also when they are in need of support. This also has specific consequences for South Asian women who may be especially isolated through ostracisation from the family and the racist environment that they live in.

3.6.7.2 Mental distress as Taboo

Many workers and senior managers feel that there is a big stigma associated with mental distress in South Asian communities. Whether this perceived stigma is any different within South Asian communities and other communities is debatable. It is interesting to note, that on other occasions, different communities (e.g. Jewish community in North Manchester and Chinese communities in Manchester) were mentioned as having stigma in relation to mental illness/distress. No one talked about this kind of stigma within white Anglo Saxon communities. So it could seem that this omission (inadvertently?) locates stigma in "other communities". This is problematic as it implies that it is the minority communities who are deficient in some way, rather than the deficiencies being located within mental health organisations.

Moreover, it could also be argued that some of the 'taboo' needs to be owned by mental health practitioners. Working with issues of suicide and self-harm generates strong feelings for all of us. Repulsion, irritation, sadness, frustration, powerlessness, feeling manipulated, and fear were all mentioned in the discussions. Similarly working with issues of 'race' and culture raises powerful feelings in us too. Therefore an alertness to our own feelings and the taboos we may impose to keep ourselves emotionally 'safe' also need to be acknowledged.

Service users' fears and how they may be operating in this context are also important to consider. Their fears may be based not only on the feeling that they are losing control, breaking down, becoming incoherent etc, but also fears about how their feelings, thoughts and behaviours will be interpreted within the predominantly (white, male, middle class, heterosexual etc) cultural lens of mental health services. For example, one worker felt that the stereotype of passivity associated with South Asian women meant that it was hard for

workers to fully accept that South Asian women do express their distress in powerful ways such as attempting suicide and self-harming. Another worker discussed how South Asian women would be judged by mental health services not only for their behaviours but also on their skin colour. Given the unimpressive record of mental health services generally in relation to Black people it is perhaps not that surprising that people may be reluctant to approach services.

It is also worth stressing that a denial of the issues of attempted suicide and self-harm for this group must contribute to the discussion on taboo. The question of *whose taboo* it is needs to be engaged with, in order that taboo is not solely attributed to 'Others'.

3.6.7.3 Community education as a response to taboo

Community education was cited on numerous occasions as a key way to encourage South Asian communities to access mental health services and to support south Asian people experiencing mental health difficulties. Like any other 'education', it is therefore important to consider what the messages of such a process would be. Some workers seemed keen for the communities to adopt a 'medical' view of mental health/illness – "it's an illness just like any other." Following this, presumably, the 'solutions' would also then be of a medical orientation rather than taking into account the social realities of South Asian women. However, given that social factors were overwhelmingly identified as factors leading South Asian women to self-harm or to attempt suicide in the survivor accounts, this reliance on the medical model presents a contradictory analysis. If mental distress can be explained as an illness and therefore specific to an individual, then the communities are absolved from the responsibilities of looking at what lies behind self-harming and attempted suicide, particularly the oppression of women. This is a much safer stance (for communities) as the woman is problematised, the 'problem' can be passed on and the notion of community and its 'izzat' or honour can stay intact.

3.6.8 Work Practices

There appeared to be three major methods in working with issues of attempted suicide and self-harm in relation to South Asian women. Firstly, the 'race neutral' or universalist approach. This is explored briefly as already much has been written about this. The second approach could be described as the gender 'neutral' approach, where issues of race and culture are privileged over issues of gender. The final way of working explored here is to do with 'matching'.

3.6.9 The 'Race-neutral' Approach

The dominance of universal or generic services was discussed in the senior managers

perspectives and illustrated the lack of planning and service provision that currently exists in relation to South Asian women and their mental well-being. Not surprisingly, this was also reflected in many of the worker discussions in mainstream services.

“I think that the service we offer in relation to the therapy, I don’t see that as being particularly different from other ethnic groups.....I don’t know whether we should provide anything different. The service we provide is open to everybody.”

Here there is a clear assumption that the therapy on offer is equally applicable and accessible to all. Similar views were expressed in different forms over the issue of language. In these discussions it was felt that therapy would be just as effective with South Asian women, providing they had a good command of English.

Hence, it is clear that the ability to speak English is seen as the determining factor as to whether or not the model or service is accessible and appropriate. No consideration appears to be given to the appropriateness of the model or service in terms of the values and underlying beliefs, nor of the recognition of different family configurations and how this might impact on appropriateness – in terms of assessment, risks of misdiagnosis or misinterpretation etc. To focus on language alone, important as it is, is only part of the story. Unless clear thought is given to whether models used are inclusive enough or what changes would be required to make them workable across a range of communities, and crucially how issues around power and inequality are addressed within the model of practice, the same problems would be replicated in another language if it is only language which prevents appropriateness. Secondly, the view was also put forward that certain modes of service delivery would be more appropriate for second generation South Asian women. This assumption warrants further exploration. On the one hand, it could be viewed as an expression that cultures are not static, that they are dynamic and fluid, hence second and subsequent generation will be more amenable to mainstream services. But at a more insidious level, it could be argued that this accommodation is more akin to ‘whitening’ – i.e. in order to ‘fit in’, there is enormous pressure to conform to the dominant culture and its expectations and not just in terms of language. Thus in this process, Asianess is likely to be devalued and whiteness is likely to be accentuated. Indeed in another discussion, practitioners felt that it was much easier for them to work with ‘westernised’ Asian people than non-westernised Asian people – and the unfairness of this was acknowledged by the workers.

Another way in which the ‘race-neutral’ approach was demonstrated was linked with issues of presence and invisibility.

“...because it’s [suicide and self-harm] not recognised as a problem, it’s hidden, not seen as a problem by me as a white [practitioner], the other [Asian practitioners] see it. So I don’t engage in a dynamic that’s about change.”

So as the problem around suicide and self-harm is veiled, this practitioner recognised both

that there was a segregation of services along racialised lines and also that her own response to South Asian women was reactive rather than proactive in terms of developing practice.

Although few discussions (apart from the ones that were in gender-specific organisations) made explicit the need for gender-sensitive services, it cannot be assumed that just because services are gender-specific they would automatically attend to the needs and concerns of South Asian and black women. There have been major challenges to white feminism from black feminists (e.g. Amos and Parmar, 1984; Carby 1982, Collins, 1990; hooks, 1981) on white feminism's silence on racism, and it is crucial that the lessons from such challenges are incorporated into the planning and delivery of mental health services.

3.6.10 Privileging 'race' over gender

Practitioners in the 'caring' services have not been immune to the criticisms levelled against provision which is universalist. In what could be described as an effort to rectify these criticisms, many practitioners have made attempts to engage with the issue of 'colour'. However, one of the consequences of this has been to over-emphasise the issues of culture at the expense of other oppressions. Within this study, 'race' was frequently privileged over gender.

In one of the discussions, the (male) workers talked about the eurocentricism of services – including questioning how appropriate the concept of for example, drop-ins are to South Asian women. However, further exploration of this demonstrated links with sexism – Asian women don't have time to attend drop-ins because of all their other domestic responsibilities! This is a way in which perfectly valid concerns about appropriateness and sensitivity of services subscribe to patriarchal thinking, hiding behind the cloak of the discourse of 'culturally appropriate services' to further disregard consideration of what might constitute appropriate services for South Asian women.

In another discussion, an example was given of the sexual assault of a young South Asian woman. When the police began their investigations, the suspects said the police were being racist in accusing them. The men were eventually convicted. What this example shows is the way in which dominant parties within South Asian communities can deploy claims of racism at the expense of sexism. The worker in this organisation also talked of how the women's organisation she works for, is frequently perceived as a threat by men within the South Asian communities, as they are seen as empowering women. Several Asian women workers in different organisations also mentioned how this response could then be focussed on them as workers, with the consequences of threats to their personal safety.

In discussions with white workers, it was sometimes said that Asian women are more oppressed than white women and that this is part of Asian culture. Given the climate of 'political correctness' and associated anxieties, it is likely that this view is more widely held than was

articulated in the discussions. Certainly, the media are in the forefront of portraying Asian cultures as backward and barbaric especially in terms of gender relations. Associated with this are the passive and submissive images of Asian women. As more than one of the senior managers pointed out, there is a fear around discussing issues of race and culture openly. White workers (and managers) seem reluctant to challenge the oppression of South Asian women on cultural grounds. Hence 'culture' becomes reified and unequal power relations based on gender are seen as acceptable (as part of the culture) within South Asian communities.

All these ways of privileging 'race' over gender have serious implications for South Asian women. While it is not being suggested here that gender should privilege issues of culture, the dynamics of both need to be recognised and worked with.

3.6.10.1 Mental distress and Cultural Understandings

The central role of cultural understandings are discussed here, specifically the issues surrounding the denial of suicide in certain communities and the role of spirituality in mental distress. The analysis offered also describes how the misuse of cultural understandings leads to ill-informed and risky assessments with grave consequences for those in need of protection and safety.

Denial of issues of suicide/self harm

In some of the discussions with South Asian workers, there did appear to be a denial of issues to do with suicide, especially for Muslim women. In several discussions, participants did not think attempted suicide was an issue and the following view was expressed as an explanation for this.

"It's against Islam to commit suicide".

Many religious faiths including Islam, Christianity and Judaism for example, believe that the right to give and take life rests with God. Therefore acts such as suicide are viewed as sinful or taboo. It would also be reasonable to assume that the taboo is stronger for women, as the expectations of the "ideal" woman in many religious faiths include an explicit embracing of the faith. In the context of minority communities, this takes on additional dimensions. The need to maintain some sense of cultural identity and belonging in a racist environment is crucial to well-being. The responsibility for ensuring that cultural heritage (of which religion is a significant dimension), is transmitted to future generations has traditionally lain with women, especially mothers (see Yuval Davis & Anthias, 1989). Hence for women to transgress religious teachings is viewed as especially shameful or sinful. However, just because there is a taboo, does not mean that people from these faiths will not express their distress in this way.

What this highlights is the ease with which the taboo against suicide in Islam can be used as a cultural stereotype of expectations about Muslim women. In fact this is a good example of how supposed “cultural” awareness can actually inhibit the development of suicide and self-harm services to this group of women. The key problem with such cultural/religious interpretations is that the cultural view put forward tends to privilege dominant hierarchies and values within those cultures (i.e. male, middle class, heterosexist ones). Within the framework of the cultural taboo against suicide, and the hierarchies inherent in most cultures, it is therefore particularly important to attend to the needs of those Muslim women who may be experiencing suicidal thoughts. It may also be possible that because of suicide being forbidden, for Muslim women the option of self-harm may seem more ‘culturally appropriate’. Indeed, there was some indication from a study on ‘race’ and drugs (Chantler et al, 1998) that Muslim people (young men in particular) used ‘drugs’ in preference to alcohol because of the strong religious taboo against alcohol in Islam.

Mental distress and Spirituality

“ it’s [mental distress] seen as an evil spirit. A lot of people won’t take the recommended dosage and the family won’t monitor the medication, then they go to the priest”.

We know how medication has been used to control people experiencing mental distress (e.g. Parker et al, 1995) and how little attention appears to be paid to the side effects of various drugs. It is not therefore entirely unexpected that service users ‘adjust’ their medication to suit them and to keep some control for themselves.

This participant’s response also brings into the arena the role of ‘alternative’ treatments such as priests and the role of ‘in-house’ cultural interpretations of both the problem and consequently the required treatments. Whilst it is the case that some people get an enormous source of strength from prayer, (as also evidenced in some of the survivor accounts) and religious rituals, religious or quasi religious interventions to deal with for example, possession of evil spirits, are just as likely to be flawed along axes of gender, class and sexuality as traditional western interventions. It is crucial to assess whether religion is being used to maintain the status quo of existing power inequalities within communities, or whether it is being used to create a genuine opportunity for growth and well being.

“ Especially in the context of women, orthodox religion has shown itself to be oppressively male-oriented.....The politics, the morality and the sociology of religious thinking, behaviours and practices must be understood before offering spirituality as a pill for mental well-being” (Davar, 1999 : 134).

The use of spiritual healers could therefore be dangerously linked with culturally appropriate services. For both South Asian and white practitioners, cultural practices can also be linked with a naïve romanticism. Hence there may be a genuine belief that Black cultures should be taken at face value, as a way of respecting cultural diversity. Similarly, in one of the discussions

white colleagues were perceived as over compensating in work with Black and South Asian clients, partly because they wanted to do their best and work in a culturally appropriate way, but partly also because they did not want to be seen as racist. However, what this could well serve to do is to further oppress South Asian women. The fears that were expressed by senior managers and workers in this study when it comes to talking about issues of 'race' in for example, ethnic monitoring, would probably escalate uncomfortably when it comes to challenging cultural practices. Fears of being seen as culturally insensitive or racist encourage a climate of silence that not only actively collude with the oppression of South Asian women, but also leads to ill informed and risky assessments.

3.6.10.2 Risky Assessments

At the time of writing, the convictions for the tragic death of Anna Climbie, aged eight, have received much media attention (12 and 13/1/2001, various news bulletins and newspapers). Anna died as a result of horrific injuries inflicted on her by her carers and the failure of the relevant agencies to protect her. There is a suspicion that cultural factors may well have been a factor in the poor assessments carried out by a range of professionals with dire consequences for Anna. Taki Suleman, lead member for housing and social services at Haringey Council told BBC Radio 4, *The World at One* (12/1/2001):

"I feel very strongly that there may have been some cultural value judgements that were made which need to be unpacked.....African families have a lot of respect for their elders. Therefore the fear displayed by Anna, as spotted by numerous professionals was [interpreted] as a result of the respect needed in African families." (cited in *The Guardian*, pg. 5, 13/1/2001).

So although the fear was spotted, it would appear this was attributed as 'normal' for African children. Presumably, the staff involved in the case felt that they were behaving in a culturally sensitive manner. This highlights two important points. First, it is not easy for practitioners to know how to work in culturally sensitive ways, and their struggles to do so need to be acknowledged. Second, it illustrates how easily 'cultural understandings' can leave the most vulnerable entirely unprotected. This is not to deny the importance of cultural understandings, but to emphasise the importance of, and an alertness to issues of power and oppression both within and outside of Black communities. Following on from this, the stereotype of the submissive and docile South Asian woman combined with the view that the oppression of women in South Asian communities is acceptable can lead to assessments which not only do not protect South Asian women, but serve to perpetuate systems of oppression based on both racism and sexism.

3.7 'Matching'

A further response to the call for culturally sensitive services has been to 'match' service users with practitioners from the same ethnic/cultural background. This method is used in work teams with a mixed staff group or by referring service users to what is assumed to be a culturally appropriate service.

3.7.1 Politics and South Asian Grass-roots Organisations

At the same time as the rush to 'match', there have also been many grass-roots initiatives from South Asian communities who know that mainstream services are failing their communities and have mobilised to offer alternatives. However, this mobilisation appears to have developed in two distinct ways. Firstly, there are South Asian organisations who are primarily motivated to keep intact family, religious and cultural values and hence tend to have a more conservative outlook, which is especially significant and (detrimental) in relation to South Asian women and attempted suicide and self-harm. These organisations, it would seem, would have much in common with the wider 'back to basics' agenda. While they may or may not be overtly anti-racist, they are not gender sensitive in terms of the oppression experienced by South Asian women and are therefore not relevant organisations for South Asian women with these particular issues. In many ways it could be argued that these organisations work in a way which privileges 'race' over gender, the consequences of which have been discussed above.

Secondly, there are more explicit gender-sensitive initiatives that work from a woman-centred, anti-racist perspective. From the analysis that has already been presented, it is clear to see that the politics of organisations and of individual workers (as illustrated above when discussing the privileging of 'race' over gender and below when looking at gender-specific services) has a big impact on what is heard and therefore what services are developed and offered. Hence the implications of homogenising all South Asian community organisations should be clear. Traditionally, challenging the homogenising tendency has been taken to mean the necessity to observe differences in culture for example, between the Pakistani and Indian communities, thus 'ethnicising' them and obscuring class, gender and other inequalities. It is argued here that in so doing, diversity in terms of unequal power relations has been made invisible both internally within South Asian communities and externally in relationships with predominantly white, mainstream organisations. Hence, it is vital that all workers and senior managers, (including commissioners and providers) are aware of the differences in the politics of the South Asian organisations they refer on to, or purchase services from, as these differences have serious consequences for the appropriateness of services to South Asian women. Similarly, a number of South Asian organisations may have partnership arrangements with the statutory sector and are also asked to provide cultural awareness training for practitioners. Clearly, all the issues identified above in terms of political perspectives has relevance for these activities too.

It is also significant that these grass-roots initiatives operate in the context of the contract culture, making collaboration between organisations difficult (as discussed in the senior manager perspectives).

Indicators of Good Practice

- Ensure that the organisations that South Asian women are referred to, (or from whom services are commissioned) do actually provide specific services to South Asian women with attempted suicide/self-harm issues
- Dedicated suicide and self-harm services that address both the generality and specificity of the positions of South Asian women
- Awareness of the different politics and hence services available to South Asian women.
- That mainstream services have a coherent strategy for working with South Asian women

3.7.2 Matching for what?

Apart from the differences in politics explored above, as Sheikh (1996) has pointed out, matching often occurs at an elusive level where one aspect of identity is latched on to regardless of other indicators of sameness or difference, such as gender or age.

A South Asian worker:

“I’m not a Muslim, I’m not religious, I’m not from the same parts as them [her service user group]. So there are differences. But I’m a woman and may have similar experiences to do with racism and cultural upbringing. I’m not able to fulfil all their needs.”

Given the plethora of variables between any two people, matching is a difficult concept to put into practice (Burman, 2000). Questions such as which variables are to be matched, what gets included and what is omitted and whose choice this is, are often overlooked in what can only be described as a desperate attempt to shift the responsibility of providing culturally sensitive services (personally and institutionally) onto South Asian communities themselves, whilst mainstream providers do little to change their own services (see senior manager perspectives).

“They [mainstream agencies] use us as a dumping ground rather than as joint workers.”

Beyond failing to take responsibility for providing a needed service, mainstream agencies are

also placing workers in contexts where they are called upon to work beyond their skills and training.

“I do have some skills, but I’m not an expert [on issues of suicide and self-harm] as for example [name of organisation], but because I’m seen as a South Asian, there are unfair and high expectations put on me”

This was also noticeable in a couple of the mixed staff teams in this study where the responsibility of providing services to South Asian women, fell upon South Asian and other Black workers – even where these workers were for example, from an African background. The working assumption seemed to be that anybody ‘with colour’ would be better than a white practitioner.

Within this, it is acknowledged that some workers may refer on because they genuinely believe that South Asian organisations (or workers) will be better equipped to meet the needs of South Asian women, and that workers who are not of a South Asian background may feel de-skilled in working with this group. However, in mixed teams where issues of ‘race’ and culture were engaged with on a regular basis, white practitioners also felt able to provide a sensitive service. Some practitioners said they “thought about it [issues of race] all the time” – both in terms of providing services and of the team dynamics of mixed staff groups. There are also wider issues at stake here including the importance of recognising ‘whiteness’ as a ‘colour’ (Charles, 1992), the dynamic, merging and continuously evolving nature of cultures, and the effects of globalisation (Littlewood, 1995). All these factors make it both possible and presents a challenge for workers, (white and black) in mental health services to provide culturally relevant services.

Indicators of Good Practice

- Increasing the knowledge and skill base, particularly of white workers to work inter-culturally.

3.7.3 Circularity of referral processes

Many workers from statutory organisation did have an awareness of South Asian organisations in their areas and said they would refer South Asian women to them. On the other hand, some South Asian organisations either did not recognise suicide as an issue, or alternatively, did not feel best placed in terms of skills and knowledge to offer adequate support for working with suicide and self-harm. They would therefore refer such service users back to the statutory sector, creating a “revolving door” whereby South Asian women are sent from one to other without having their needs met.

3.7.4 Confidentiality

Confidentiality was raised as an issue in many of the worker discussions in relation to matching. Whilst service users' choices need to be respected, at the same time it is important that the professionalism of South Asian workers is not undermined. Clearly breaches of confidentiality are not compatible with professional standards of practice. Service users may be fearful that workers will be asked for information from other family/community members. Additionally, due to the potential of overlapping of networks between different South Asian practitioners and service users (because of the smallness of communities), it is often difficult to maintain the level of anonymity required for service users to feel safe. Hence service users who would prefer a South Asian worker often find it easier to exercise this choice if the worker does not live in the same area as the service user.

Indicators of Good Practice

- Choice of (gender, ethnicity etc of) worker to rest with service user
- 'Held' confidentiality in line with organisational policy
- South Asian workers from a range of geographical locations

3.7.5 Committed South Asian, Gender-specific Organisations

Despite the reservations discussed above regarding 'matching', at the same time, there are some very positive, powerful and supportive South Asian services and interventions. These are being made by gender-specific organisations who are also operating from an anti-racist stance and are able to 'hold' and take appropriate risks around the complex work of attempted suicide and self-harm as it relates to South Asian women. An important way of working was identified as 'harm-reduction' (rather than trying to stop the self-harm) and support through talking, rather than automatically referring women onto the psychiatric services. As one of the workers in such an organisation said:

"Sometimes the way we [workers and service users] talk about taboos, about self-harm, about sexuality and other issues is so special, it sometimes feels ground-breaking."

Such organisations, particularly South Asian women's refuges emerged as crucial to providing support services to South Asian women at risk of suicide and self-harm. In contrast with their current status, they need to be properly resourced and strengthened, and recognised as important partners in the provision of mental health service to this group - currently, this is not happening. It is also vital that monitoring and evaluation processes do not stifle the growth of such organisations.

“More and more we’re being pressurised to have very strict standards, we’re much more sanitised, void levels, health and safety, so much emphasis on monitoring. Funders are only interested in the number of women, not about the issues.”

Indicators of Good Practice

- Gender-specific, woman centred, anti-racist services
- Managing risk creatively
- Inclusion of strategies to combat social inequalities
- Harm-reduction strategies in relation to self-harm, ensuring at the same time that emotional needs are attended to
- Effective partnership working⁷
- First language interventions
- Appreciation of religious and cultural contexts
- Appropriate qualifications and/or experience for the role

Working with issues of attempted suicide and self-harm is skilled and complex and needs to be recognised as such. Clearly the need for support and clinical supervision is essential and it is to this that attention is now turned.

3.8 Staff Development, Support and Clinical Supervision

“I feel angry and pissed off, [about abuse], really fucking angry and sometimes I feel out of control. You want to give so much, but you can’t. You can’t tell her that all those [emotional] scars will heal, there are no securities.”

It is plainly clear from the above, that practitioners in this area of work need to be properly supported and be offered high quality clinical supervision. Given the wide range of powerful feelings that are evoked both by issues of attempted suicide and self-harm and issues of race and culture, it is essential that workers’ support needs are attended to and that safe practice is developed and sustained. Central to effective clinical supervision is the need to separate management tasks (case-load management, outcomes, work routines, holiday and sickness etc) from the process issues of working with individual service users. It is encouraging that

⁷ Often wrongly assumed to be happening - “one of the most frequent recommendations in previous reports on mental health services is for better communication between staff” (Safer Services. 1999:85). In this study, effective partnership working also applies to working towards a more equal relationship between mainstream and South Asian organisations.

several organisations interviewed had this system in place, usually through an external supervisor.

Supervision is also an arena where workers can develop their practice through being constructively challenged in a supportive supervisory relationship. For practitioners working in suicide and self-harm with South Asian women, clinical supervision should also provide an ideal opportunity for developing practitioners' practice and understandings in specific ways for a particular service user from generalised understandings about attempted suicide and self-harm, and about issues of 'race', culture and gender. In terms of staff development, the majority of practitioners felt that training on these issues would be important in enhancing their practice. Whereas training events could be organised, the immediacy of discussing such issues in supervision is also to be encouraged.

Whilst there were some organisations that separated management and clinical supervision, many did not and some had no formal supervision arrangements in place. In some cases workers themselves did not see the need for supervision or understand the benefits of it. In the majority of organisations, informal peer support was the norm. Noticeably, counselling services or organisations who described themselves as having a counselling culture tended to have rigorous yet supportive supervision in place. This is not unsurprising as the world of counselling and therapy probably has the most developed models of clinical supervision.

It is of concern, therefore, that clinical supervision was not considered essential in certain organisations involved in the study. The need for clinical supervision to be more widely available is urgent – this is not a luxury, but is essential to safe practice and quality services (as professional trainings and organisations such as BACP and UKCP agree).

It is correspondingly even more worrying that some practitioners also need to offer “talking therapies” when they had no relevant qualifications or experience in this field. This is unsafe practice which leaves service users in a very vulnerable position. It cannot be emphasised too strongly that talking therapy is skilled work and needs to be recognised as such. From the survivor accounts it is clear that the need to be understood, to be listened to, to be heard and to be given time are of prime importance, hence skills in these areas are essential. Significantly, also from the survivor accounts, neither would it be safe to assume that just because workers are professionally trained, that they are equipped with these skills. Indeed, many survivors voiced a need for survivors' groups indicating that this where they would feel best understood. The experiences of survivors therefore indicates the need for a range of provision, including support workers, therapists and survivors groups (see survivor accounts).

Within the general need for support and supervision, two groups of workers emerged as having specific needs. First, the support needs of interpreters and link workers are often overlooked. They are often party to hearing distressing and upsetting material, and the impact of this on them needs to be acknowledged. The role of link worker or interpreter can make the interpreter seem invisible, as the interaction between practitioner and service user is

perceived to be the most significant. Second, is the need to ensure proper protection and safety measures for South Asian women workers, especially those who may be viewed as a threat to male dominance. Encouragingly, South Asian women workers who were subject to such personal threats, reported that they were on the whole well supported.

Indicators of Good Practice

- Separation of management issues from clinical supervision
- Adequate support for link workers and interpreters
- Appropriately qualified or experienced workers for the provision of 'talking' therapies
- Recognition of issues of personal safety for South Asian women workers
- Developing practice through open discussion of attempted suicide/self-harm and 'race', culture and gender issues
- A range of service provision including support work, therapy and survivors' groups

3.9 Summary

There appeared to be a common understanding amongst workers of what self-harm behaviour was and the meanings that were ascribed to this. Significantly, no particular methods were perceived to be specific to South Asian women. There was also a shared understanding that self-harm was a way of dealing with difficult and painful emotional issues by diverting attention away from the emotional to the physical to provide a temporary sense of relief and well-being. Intention to kill oneself was seen as a major difference between self-harm and attempted suicide. However, the relationship between suicide and self-harm is complex. Self-harm is both a protective factor against suicide (Spandler, 1996) and a potentially high risk factor in suicide (Hawton & Fagg, 1988). It was disappointing to note that despite some good practice around attempted suicide and self-harm, there is still the perception that people who self-harm or with repeat suicide attempts are attention seeking and a drain on resources as the injuries were self-inflicted.

Many workers (white and black) talked about the problems of living in two cultures and the difficulties encountered in negotiating the differences. They saw this to be a key factor in South Asian women self-harming and attempting suicide. Significantly this was not mentioned by any of the survivors. The 'culture clash' analysis has several drawbacks. First, cultures are seen as essentialised, fixed and rigid rather than as dynamic and evolving. Second, implicit within this is the notion that it is only 'Asian' culture that is affected by the difference, so that examples of the way in which aspects of Asian culture impact on the rest of society are overlooked and minimised. Third, and probably most important, what the 'culture clash'

analysis does is to de-contextualise and to mask, ignore and perpetuate unequal power relations and to intervene in ways which make services inaccessible and insensitive to those whom they may be trying to reach. More specifically, this approach fails to engage with or to acknowledge issues such as sexual abuse, domestic violence, racism, immigration, patriarchy, forced marriages, and poverty. These are systemic and structural, and are very clearly articulated in the survivors' accounts.

In comparing the experiences of distress of white women and South Asian women, it needs to be understood that even where factors are in common with white women (e.g. domestic violence, sexual abuse), access to services for Asian women is far more difficult. Coupled with racism, isolation is much more acute with correspondingly fewer options to turn to.

It is therefore crucial both for the understanding of South Asian women's distress and in making services more sensitive, that wider social issues are addressed – both in the configuration of services and in the training and perspectives of workers in the field.

The analysis of the National Service Framework for Mental Health (Standard 7) illustrates the ways in which mental health policies continue to exclude and omit the concerns of minorities, in this case women and Black people.

Three key approaches were shown to influence work practice in relation to South Asian women and mental distress. These are the 'race neutral' approach, the 'gender neutral' approach and 'matching'. The 'race neutral' approach is based on the idea of universality, that the same service is suitable for all.

The analysis of the 'gender neutral approach in this study highlighted in particular the privileging of 'race' over gender. 'Race' anxiety, fears around 'political correctness' and the reluctance to challenge what are assumed to be cultural practices, all reify culture, and hence unequal power relations based on gender can be seen as acceptable (i.e. as part of the culture) within South Asian communities. The stereotype of the submissive and docile South Asian woman combined with the view that the oppression of women in South Asian communities is acceptable can lead to risky assessments which not only fail to protect South Asian women, but serve to perpetuate systems of oppression based on both racism and sexism.

Neither is it being suggested here that gender should privilege issues of culture, but rather that the dynamics of the two are recognised and worked with. This is not to deny the importance of cultural understandings, but to emphasise the importance of, and an alertness to issues of power and oppression both within and outside of South Asian communities.

A further response to the call for culturally sensitive services has been to 'match' service users with practitioners from the same ethnic/cultural background. Given the plethora of variables between any two people, matching is a difficult concept to put into practice. Questions such as which variables are to be matched, what gets included and what is omitted

and whose choice this is, are often overlooked. Within this, it is acknowledged that some workers may refer on because they genuinely believe that South Asian organisations (or workers) will be better equipped to meet the needs of South Asian women, and that workers who are not of a South Asian background may feel de-skilled in working with this group. However, it is urgent that white workers develop their knowledge and skills to enable them to work inter-culturally. It is equally urgent that workers in South Asian organisations are helped to develop the competencies required to work in this field. An important finding to emerge from this study is the gaps in service provision created by a circular referral process. Statutory agencies refer South Asian women service users to some South Asian organisations who do not feel equipped to deal with issues of suicide and self-harm and thus refer them back to the statutory sector. Hence the needs of vulnerable South Asian women are clearly not being met by this process – either by the statutory sector or by (some) South Asian voluntary sector groups.

In relation to South Asian groups offering services in the mental health area, it is vital that all workers (including commissioners and providers) are aware of the differences in the value base or politics of the South Asian organisations they refer on to, or purchase services from, as these differences have serious consequences for the appropriateness of services to South Asian women. However, some very positive, powerful and supportive South Asian services and interventions were identified. They are being made by gender-specific organisations who are also operating from an anti-racist stance and are able to 'hold' and take appropriate risks around the complex work of attempted suicide and self-harm as it relates to South Asian women.

Given the complexity of work in this area and the wide range of powerful feelings that are evoked both by issues of attempted suicide and self-harm and issues of race and culture, it is essential that workers' support needs are attended to and that safe practice is developed and sustained. Central to effective clinical supervision is the need to separate management tasks from the process of working with individual service users.

It is clear that in order to provide effective mental health services to South Asian women, specifically in the area of attempted suicide and self-harm, several key factors are essential: an understanding of contributory factors in suicide and self-harm, the ability to work inter-culturally, appropriate competencies for the role in question, alertness to the dynamics of 'race' and gender, gender-sensitive and anti-racist services, managing risk creatively, and good quality supervision.

4 SURVIVOR ACCOUNTS

Central to this study are the survivor accounts. Their accounts were drawn upon to influence and shape the rest of the research, in terms of the issues explored with workers, senior managers and South Asian communities. In particular, issues emerging from the survivor perspectives were shared as appropriate in the interviews with senior managers. Similarly, any new service developments for South Asian women attempting suicide, or with self-harm issues, need to be based on a clear understanding of the factors contributing to distress, the personal meanings attributed to such distress, as well as service users' experiences of services, in order that interventions can be developed which reflect their needs and concerns. This strand of the research therefore focussed on South Asian women survivors and involved in-depth interviews with them.

4.1 Terms - Survivors, Attempted Suicide and Self-harm

Within this study, survivors were taken to mean women who had survived suicide attempts and/or who self-harmed. The study did not aim to work with a specified age-group or cultural background. Keeping an open mind about both age and cultural background was important as no particular assumptions were being made about how these factors might (or might not) be linked with suicide and self-harm issues. No specific definitions were offered to survivors about attempted suicide or self-harm either as it was felt important that the women talked about their own understandings within their own frameworks. Starting from this position meant that it was possible to explore how women themselves saw and understood their actions and behaviours.

4.2 Ethical Considerations

Ethical clearance for this part of the study was given after scrutiny of the design by the Manchester Metropolitan University, Department of Psychology and Speech Pathology. Purely due to the limited time scale of this project, ethical clearance was not sought from the statutory health sector. This clearly had implications for contacting survivors and meant that we only worked with voluntary sector agencies and through informal networks. However, it is important to note that the survivors who participated in the study had also had various levels of contact with statutory agencies and there are many lessons to be learned from their accounts, as the findings illustrate.

Given the sensitive nature of the discussions and the possibility that painful issues may be re-awakened, every effort was made to ensure that additional support was available to those survivors who felt they may need it. This was negotiated with the referring agency. Where

support was not possible via the referring agency, arrangements for support had been made with 42nd Street and the Trafford South Asian Mental Health Project.

4.3 Contacting Survivors

It was assumed that reaching survivors would be difficult, however, this proved not to be the case. In itself, the fact that survivors were readily identifiable and willing to participate in this research, illustrates the need for appropriate services to South Asian women. As well as informal networking, contact was made with a wide range of voluntary sector organisations and workers who could contact survivors were identified. It was important to have an independent person (from the research) to make the initial contact with potential participants to ensure that consent to participate was given freely. An information sheet was prepared for potential participants. Prior to agreeing to be interviewed, potential participants were able to discuss any queries arising from the study with me.

(The interview schedule is in Appendix 5)

4.4 The interviews

A total of 7 survivor interviews were held. Survivors were given the choice of language in which they would prefer to be interviewed. 6 of the 7 interviews were held in English, the seventh was in Urdu for which an interpreter was used. The interviews were in-depth and loosely structured to allow flexibility, and to facilitate participants to tell their stories in their own ways. The interviews sought to gain an understanding of the following:

- The factors that contributed to their distress
- The meanings attached to suicide attempts and self-harming
- Survivors' coping mechanisms
- Survivors' experiences of services
- Survivors' views of what would help to support them (and others) with issues of suicide and self-harm.

4.5 Confidentiality Arrangements

Confidentiality and anonymity were carefully negotiated throughout the process, from initial contact with me, at the beginning of the interview and checked again at the end of the interview. Permission was asked to tape the interview, this was given by all the participants. Material from the interviews is presented here, according to the arrangement negotiated with participants. Identifying information has been removed when highlighting salient points of their accounts. The interview material and discussion around it remains confidential.

4.6 Introduction

The findings presented from the survivor accounts are clearly about acute forms of distress. In writing about such distress, it is hoped that the reader will not conflate ideas about the oppression of South Asian women as integral to South Asian cultures without making the corresponding links to the oppression of women in white cultures. Significant also, is the often unspoken alliance between white, racist patriarchy and South Asian patriarchy. Hence the difficulties in highlighting issues of abuse, violence and distress in South Asian communities, include how these aspects tend to be over-emphasised in many contexts (e.g. through the media), giving rise to racist interpretations of South Asian communities. In a parallel process, the racist environment within which we live can also contribute to the under-emphasising of issues of abuse and violence in South Asian communities by those who reify such communities or those who are afraid that they may be perceived as racist. The findings and analysis presented here, based firmly on the survivors' stories, aim to unpack key elements of the complex and layered dynamics at play in working with issues of attempted suicide and self-harm in South Asian women. Central to the analysis are the concepts of "private"/ "public" spaces as well as the links between the personal and the political.

More specifically, this chapter explores the factors contributing to South Asian women's distress, coping mechanisms used to deal with distress, the mirroring processes between helping agencies and families/communities, survivors' experiences of helping agencies, and survivors' ideas about what would be more supportive to them.

4.7 Factors contributing to Attempted Suicide and Self-harm

A range of inter linking factors were mentioned as contributing to suicide attempts and self-harming. These were: sexual and physical abuse, domestic violence, immigration issues, forced marriages, racism, and issues of loss. Issues that were closely allied and generated a lot of stress included poverty and homelessness. Although these issues are sometimes discussed separately in this report, it is important to note the way in which factors work in conjunction with each other to create oppressive conditions. A further reason in considering issues separately is to provide as much anonymity as possible for the survivors who participated in the study.

The age range of survivors interviewed was from 17 years to 30 years. The most common method used for suicide attempts was through overdosing although other methods were also used: hanging and slashing of wrists. Those who self-harmed cut themselves, used burning, drank substances such as bleach or head lice shampoo, or misused substances including food, alcohol and illegal drugs. Significantly, three of the survivors either attempted suicide or started self-harming in their early teens and five of the survivors had attempted suicide more than once.

A key theme clearly emerging from the survivor accounts are the links between domestic violence in particular, and attempted suicide and self-harm. All but one of the survivors interviewed, had experienced domestic violence. Domestic violence is taken to include emotional, sexual, physical and financial control and violence.

4.8 Domestic Violence

World-wide, men's violence against women causes more deaths and disabilities among women aged 15-44 than cancer, malaria, traffic accidents or war (Murray and Lopez, 1996). In the UK, the largest increase in violent crimes since 1981 has been in incidents of domestic violence (British Crime Survey, 1996). Furthermore, every week, two women are killed by their partner or ex-partner in the UK (Refuge, 1999).

One of the survivors:

"I didn't have enough money to buy things, only £5 a week for one and a half years. He started seeing other women and taking drugs, he started hitting me. He used to smack me, punch me, pull my hair, throw me against walls and the wardrobes, he'd throw things and break things".

Traditional attitudes towards domestic violence have tended to blame women for the violence that is inflicted on them (Hague and Malos, 1993). Men's violence is often excused on grounds of alcohol, frustration or provocation. Rather than men's behaviour coming into focus as a 'private' reflection of 'public' or wider unequal gender relations, (e.g. Maynard, 1993), the gaze is turned towards the woman and her behaviour. This focus on the woman's behaviour is problematic as firstly, it feeds into the guilt and blame she may already be experiencing. We know from survivors of abuse that blaming oneself is a part of the abusive process, actively encouraged by the abuser to justify his violence. Secondly, this process helps to maintain silence and keep domestic violence 'private'. Indeed, the privileging of 'privacy' over violence to women is still a current feature of much police (as one of the survivor accounts illustrates) and court decisions on domestic violence. Thirdly, by 'privatising' domestic violence, wider social considerations (e.g. housing, finance), which impact on women wanting to escape are ignored and marginalised.

Within the abusive relationship quoted above, this survivor and many of the others interviewed in similar relationships attempted suicide and/or self-harmed. As Davar notes: "Social conditions, and especially violence precipitate mental distress [for women]" (1999: 135).

The question of pathology needs to be shifted from seeing women as pathological in encountering or tolerating abuse to seeing the environment she lives in as pathological. What seems very clear from the survivors accounts in this study as elsewhere (Arnold, 1995, Pembroke, 1994), is that suicide attempts and self-harming appear to be a 'rational' response

to such violence and brutality, rather than a mental 'illness'. Whereas the generalities of domestic violence as discussed above are important, the specificities of South Asian women's experiences of domestic violence also need to be attended to. Hence considerations and understandings of domestic violence and distress also need to be located within the context of racist housing policy, racial harassment, immigration, as well as cultural concepts such as honour and shame. It is to these specificities that attention is turned to next.

4.8.1 Domestic Violence and Housing Policy

Clearly, the need for alternative housing is a pre-requisite for any woman leaving a violent relationship. The specific issues for South Asian (and other Black) women are foregrounded by the racism and sexism inherent in much housing policy and practice (e.g. Bryan, Dadzie and Scafe, 1985; Mama 1989). As noted by Mama, "The single black woman, the single black mother....and [others] seeking to escape violence are all likely to be offered inferior housing or none at all" (1989:101). This reflects one of the survivor accounts in this study, where her experience with the housing department both let her down and put her life in danger. She reported going to the housing department with her baby, escaping an abusive relationship:

"They said we'll [the housing department] give you a place in a couple of days, so they lied to me, I never got a place. It's not a game, but they should be more helpful. I was homeless, shouldn't have to go to police. It's scary, they might lock us up."

In the event, the housing department failed to contact her again and she had to flee from her temporary 'safe' space as her family had found out where she was. Hence the inaction by the housing department contributed to her having to run again, this time with very little faith in the housing department. As the Refuge report (1999) makes clear, all women escaping from violent relationships are in potential danger from their ex-partners/husbands, even when they have left the relationship.

In terms of other specificities of experience, the smallness of South Asian community networks makes it very easy to locate South Asian women who have escaped and thus speed of response in housing matters is crucial. As some of the other survivor accounts also highlight, many South Asian women feel safer in a different town or city to where the abusive partner/family is. However, there are also costs, as in so doing the woman may well come to a place where she has no connections, friends or family. As one of the survivors said:

"Either we stay there [within the family] and suffer or just get out of it. So-called community. I know no-one here, but I'm happy as I am."

But also:

“I feel scared, everyone’s got a family, I feel an odd one out. Will I never see them again?”

The isolation and loneliness that ensues cannot be under-estimated, neither can the courage and strength required to follow through this course of action. The popular stereotype of service providers that ‘Asian families care for their own’ (e.g. Bingley et al, 2000), is challenged by South Asian women fleeing from violence and abuse, illustrating very plainly that this is not the case. Neither can the other popular image of South Asian women as passive victims be maintained in the light of the struggles of the survivors in this study and elsewhere (Yazdani, 1998). What these accounts highlight is the need for agencies to be alert to the specificities of South Asian women’s experiences, to recognise not only their needs and vulnerabilities but also to value their strengths and creativity and to ensure that their services do not militate against South Asian women’s strengths.

4.8.2 Racial Harassment

In another of the survivor accounts, to try to ensure her safety and to be ‘invisible’ within the South Asian community, she chose to live in a white area after escaping from a violent relationship. (This strategy for survival clearly also has implications for how accessible ‘traditional’ South Asian community organisations may be to such women). Whereas this strategy did give make her ‘invisible’ to South Asian communities, she was at the same time very ‘visible’ in the white community. She and her children were subject to racial attacks in their home and neighbourhood, illustrating how difficult it is for South Asian women to find a ‘safe’ place. In these contexts, notions of safety can be extremely tenuous.

4.8.3 Domestic Violence and Immigration: Unholy Alliances

It was through one of the survivor accounts that the powerful and oppressive links between domestic violence and immigration law came to light. She came to England from Pakistan, after marrying her husband who was permanently settled here and was therefore subject to the immigration “One year rule”. Underlying the one year rule is the assumption that people who come as a spouse to somebody who is permanently resident in this country are coming primarily in order to settle here for immigration purposes rather than marriage purposes. Hence the assumption is that such marriages are ‘bogus’ until proven otherwise. The test that has been set to ‘prove’ the marriage is genuine is for the marriage to continue with both partners living together for a year. If within the year, the marriage does not work, foreign nationals would be deported, unless there are compassionate grounds.

In this survivor’s case, the marriage began to fail shortly after she joined her husband. She was beaten severely on a regular basis, she was exhausted from being made to do all the housework, she was refused access to the GP, and was isolated from her family and made to feel worthless and unwanted. Her sense of being trapped was magnified by the strong likelihood

of deportation were she to leave the marriage. To be deported in this situation, involves a very public humiliation of a failed marriage, for which women are seen as responsible.

“I don’t really want to go back to Pakistan, to listen to all the people talking about me. That kills you more, even though you are alive, you’re almost dead, inside you are dead . People blame the woman – not the man, the woman is guilty”.

It was this combination of interlocking factors – immigration, domestic violence and shame that led her to attempt suicide. During the research interview, she reported that she had been feeling suicidal recently (although she had left her marriage), as she was still waiting for her immigration status to be resolved. So now, the main cause of her distress is to do with immigration.

“ I think about it [suicide] a lot, the last two weeks have been awful will I get my visa or not?”

Her corresponding sense of relief and well-being is clear in the following:

“If I get my stay [right to reside permanently in the UK], I will enter the world again”

This account raises several significant points and the discussion presented here follows some of the points made by Battarcharjee (1997) in her analysis of the impact of US immigration laws, domestic violence and South Asian women.

This survivor account, firstly, illustrates the way in which racist immigration laws, designed by the white patriarchal state align with patriarchy in South Asian communities to oppress South Asian women. Hence, marriage which is frequently assumed to be a “private” space, is made a “public” space by the violating intrusion and collusion of the state through the one year rule. Second, whilst western feminists have urged women to speak out publicly about their private lives in order that connections can be made and silences ‘given voice’, this is based on the assumption that *there is* a public space which can act as a site for resistance and challenge. In this context, as Battarcharjee points out, public space is also predicated on the notion of women as citizens – clearly a very different position to South Asian women subject to the one year rule (or women asylum seekers). Such South Asian women therefore do not have access to this public space as the nation-state operates very much more like a private club exercising control over its membership. This arrangement between the ‘private club’ (white, racist patriarchy) and its ‘gatekeeper’ (South Asian patriarchy) gives rise to the potential for the exploitation and abuse of women as evidenced in this survivor’s case. As she said:

“The one year rule causes a lot of problems. The law has given all the power to the man. They can control women for a year. The law has given the man the power to treat me as he wants, I have no protection under the law, it has given the man the right to use me as he wants. It’s all in his hands, I’ve got no rights”

Controlling women via their immigration status also emerged in another of the survivor accounts, with passports and other forms of identification being withheld from women by their abusers, thus further restricting opportunities for participating in public life e.g. enrolling at colleges, access to benefits and the right to escape abusive relationships.

4.8.4 Concessions to the "One Year Rule"

Through the campaigning activities of largely South Asian women's groups both nationally (e.g. Southall Black Sisters) and locally (Saheli and South Manchester Law Centre), there have been concessions to the one year rule which are intended to benefit women in abusive relationships. These came into force in June 1999. However, in practice it appears that very little has changed for women subject to the one year rule (personal communication, Nadia Siddiqi, South Manchester Law Centre). This is largely due to level of evidence that the woman is required to produce to claim domestic violence. Acceptable forms of evidence are seen to be an injunction, or non-molestation order against the husband, a relevant court conviction or full details of a relevant police caution against the husband. Significantly, a report from a women's refuge is not considered as acceptable evidence. It is quite bewildering as to how women who are from a different country, who do not know about the "systems" (of courts, injunctions, police etc) in this country, and especially for those who do not speak English, are expected to assemble the sort of evidence required by the Home Office. This is quite apart from what we know about domestic violence and the reluctance with which women (including white women) report such incidents and follow it through to court actions or injunctions because of (legitimate) fears of further attacks. It can be concluded from this that firstly, the concessions made so far to the one year rule are going to have very limited benefits for women in violent relationships. Secondly, it further advances the view that women are untrustworthy – whether as women in abusive relationships or indeed as workers, given that a report from a refuge is not considered adequate evidence. Third, it also makes it clear that what is most important to the state is to regulate citizenship even at the expense of terrible abuse to women. In this sense, the state can be seen to be an active partner in the violence against women. Hence despite the concessions, it is clear that the survivor account and the analysis offered above is still as relevant now.

4.8.5 Immigration and poverty

A further way in which the state plays a role in the subjugation of women subject to the one year rule, is that such women do not have recourse to public funds. Hence, the principle in welfare policies with regard to the 'safety net' does not apply in this case. Without any access to benefits, it is plainly extremely difficult for women to leave abusive relationships. Exercising absolute financial control over women is a recognised feature of many violent relationships and here we see the state legitimising and participating in the oppression of women through with holding funds for basic necessities. As this survivor said:

“Agencies can’t help because of the law. It’s been my family that’s helped me with money and with the immigration. It’s because I haven’t got stay I can’t get benefits. I didn’t ask for any money from my husband. There should be some kind of support. What about those women who don’t have family here?”

Hence access to ‘public’ funds for survival has in this case become a ‘private’ matter for the family. And if there is no family, the “choices” for women are very bleak indeed. At a wider level, there are many links between this survivor account and issues facing asylum seekers, who may similarly find themselves with very few “choices”.

Indicators of Good Practice

- A clear grasp of how systemic issues contribute to distress
- Recognition of the links between domestic violence and distress
- Quick and easy access to ‘safe’ housing
- Campaigning role in relation to systemic issues e.g. on immigration, poverty etc.
- An appreciation of the specificities of experience in relation to South Asian women
- Practical ways of supporting women who have no recourse to public funds
- Effective multi-agency working

4.9 The ‘Allowing’ of Forced Marriages

A distinction is made here between arranged marriages and those that are forced. As the name implies forced marriages are ones where the young people involved, especially young women, have no say in the marriage and where violence may be used to coerce them. It is the issue of forced marriages that emerged in two of the survivor accounts.

“She [survivor’s mum] took me to Pakistan and got me married. It wasn’t even a proper wedding. I started screaming and shouting, really you know, then I tried to kill myself, obviously they got me married at 13, a kid, and they put me into another kind of cage or something and the people there weren’t helping, they were being very cruel and I got a knife and tried to kill myself but they caught me and slapped me up and locked me up in an empty roomthey wouldn’t let me do anything, just gave me food inside there. My parents were there and they weren’t doing nothing about it”.

Significantly, this survivor and her family were known to Social Services as there had been serious child protection issues and she had spent time in a children’s home as a result. How she came to be returned to her parents, and taken away to Pakistan at 13, to be married is both worrying and shocking. The role of the school also comes in to the spotlight here – how

was her long-term absence conveyed to her school? This case invites questions about what the school and the social services department should have done to protect her further. Clearly, it is not possible to know the exact circumstances of how this situation came about, but it may be possible that ‘cultural knowledge’ was at play (see worker discussions for a fuller explanation of how reifying culture leads to risky assessments).

Even more distressing, is that the very same situation with this particular survivor arose a second time a couple of years later, with a second forced marriage, described as:

“He’s raped me, continuously raping me, all night every day after he got married to me, he wouldn’t stop, sickening you know”.

(Survivor, aged 15 at the time of the second forced marriage)

This precipitated a second suicide attempt through overdosing.

In another of the survivor accounts, a very similar story unfolded. She too had been taken into care as she had been sexually abused. She self-harmed using a variety of methods including: cutting, over-eating/starving herself, jumping down staircases, burning, and drinking bleach. She was then returned to her family when she was fourteen years old, taken to Pakistan and forced to marry. This is when she tried to kill herself by hanging.

What these accounts illustrate, is not only how their families failed these survivors, but also how those agencies who are charged with the responsibility to protect children failed them completely. In this sense, they too have to accept their share of the responsibility in ‘allowing’ forced marriages.

Indicators of Good Practice (see also worker discussions – ‘matching’)

- Schools playing their proper role in ensuring that young, South Asian women are not denied their statutory right to education
- Child protection assessments that confront issues around forced marriages without resorting to cultural stereotypes about South Asian communities
- A safe, confidential space where young South Asian women can discuss their issues (e.g. through school counselling services)

4.10 Exploitation of Vulnerable People by the Psychiatric System

One of the survivors interviewed reported being emotionally and sexually exploited by the

mental health organisation that was supposed to be 'helping' her with her distress.

"... and he took advantage of me in that way ...and I wasn't very well at the time. I went there for treatment and look what the treatment I got."

This gave rise to increased distress, with further suicide attempts.

What her story demonstrated is the ease with which 'caring' professionals through their roles have the potential to exploit and abuse those in their care. Issues of power relating to job role, the nature of the institution, gender, 'race' and vulnerability of those being cared for are all important features of such abuse. Clearly, the higher the position within the hierarchy that a 'worker' occupies, the greater the potential there is for abuse to go unrecognised in the absence of proper accountability procedures.

Whereas such abuse should never have happened, it was re-assuring that she was supported by other mental health staff in her efforts to take action and make 'public' her 'private' exploitation. However, this process in itself required strength and courage, involved risks, and was at great emotional cost to her.

Indicators of Good Practice

- Rigorous and workable accountability procedures for all mental health professionals, including consultants
- Clear understanding of boundary issues
- Appreciation of the power dynamics between workers and service users
- Easy to use complaints procedures
- Supporting service users to use complaints procedures

4.11 Impact of Loss

As the National Service Framework for Mental Health indicates, people who have lost a close relationship can be vulnerable to suicide. Within this study, two of the survivors interviewed had experienced losses which contributed to their self-harming or suicide attempts.

4.11.1 Childhood Migration

One of the survivors had come to England when she was eight years old. She had a profound sense of the losses associated with migration, particularly being apart from a very special

mother figure, the freedoms she enjoyed in her country of birth, and her sense of belonging.

“I didn’t really want to come here. I didn’t.....it’s just this place England and it make me worse, I don’t feel like I belong here..... everyday when I get up and go to sleep I think will I ever get to go back to [name of country of birth]. I don’t know this doesn’t feel like home, I always think this is not my country, I shouldn’t be here. That’s why it’s so easy for me to pick up tablets here and try to kill myself. There’s love and respect in the community over there, not like here.”

Although there were other inter-connecting issues that also contributed to self-harm and attempts at suicide, her sense of loss linked to settling in England was very powerful throughout the interview.

4.11.2 Loss through Death

Another of the survivors had lost her mother, with whom she had a very close and loving relationship. She had felt that her mother had always been there for her, had protected her and supported her when things were difficult. The relationship was described in the following way:

“I wish my mum was alive so I could, you know, I used to put my head on her belly you know and say look I’m hurting and she used to hug me, she was three times as strong as me and that’s what I really miss cos now I can’t do it.. that comfort, I only felt it with my mum... I look for it [love and comfort] but I haven’t found it yet. I don’t think I ever will, to feel that, it’s impossible.”

She went on to say that if her mum had been alive, the other issues in her life would never have escalated and so she probably would not have attempted suicide.

4.12 Survivors’ Experiences of Helping Agencies

The survivors interviewed had contact (some of it still current) with the following agencies: police, housing, social services, education, social security, home office, women’s refuges, primary and secondary care mental health services and specialist South Asian mental health services. The survivor accounts and analysis already presented points to a failure of a wide range of services in meeting the needs of South Asian women. Here, we present further evidence of survivors’ experiences.

4.12.1 GPs

By and large women had not been in touch with their GPs prior to their suicide attempts or about their self-harming, suggesting that contact with medical services was made after a suicide attempt. Some survivors were denied access to their GPs, by their husbands, particularly those in violent relationships.

“GP recognised that I was under pressure and stress... but the GP [also] told me I was thinking about things too much. GP offered to talk to family, but I didn’t want this as it might make things worse. They [in-laws] only let me go once, another time they refused to let me go.”

This GP intervention was not seen as particularly sympathetic or helpful as it implied that the survivor was responsible for her own stress for thinking about things too much. No counselling or other therapy was suggested.

Most survivors were in contact with their GPs after their suicide attempts, particularly when referred by the psychiatrist or A&E departments. At this point, many were offered antidepressants. A couple of women were offered counselling, and one took up the offer as she was referred to a specialist South Asian mental health service which she found supportive.

4.12.2 Community Psychiatric Services

However, as shown below, not all survivors appreciated attempts at ‘matching’.

“And I went to see her [CPN] and she said to me I can’t really do much for you because you come from the Asian community, I’ll refer you to somebody that’s Asian, [who was not a CPN] that’s what she said...she said there’s not much I can do to help you cos of your culture and I think that they should.... They should go out there and learn about it and help people because that’s what we’ve done, we’ve mixed in with the English community very well, I have and I can understand what they’re saying and everything and they should do the same thing for Asian people, they should learn more. Sometimes I get the feeling that they don’t want to learn, they don’t want to know which is very upsetting.”

This speaker is clearly advocating that mental health workers need to be able to work competently across cultures. Also important to note is the accommodation and adaptation that this survivor has made in relation to white cultures – something which she does not perceive as being reciprocal. Clearly at a time when community psychiatric nursing is deemed appropriate, it is not very ‘caring’ to remove choice from a service user as to what their preference of worker is, or secondly to refer the service user to somebody who is not a CPN. Hence ‘culture’ becomes privileged over the service user’s mental health needs (see worker discussions – ‘matching’ for a fuller discussion). Moreover, it could also be argued that what is a ‘public’ service (community psychiatric nursing) is drawing boundaries to exclude service

users based on 'race' and therefore essentially operating as a 'private' concern with the right to control membership.

4.12.3 Psychiatry

On the whole, psychiatry was not viewed upon favourably by those women who had contact with psychiatrists as evidenced by these survivors' comments:

"He [psychiatrist] didn't know what I was talking about it, he didn't understand.

And:

"I didn't like seeing him I saw him twice and decided not to go back. Instead of him trying to understand my problems he just kept on filling my head with how he could get me a sick note and how I wouldn't have to work, he was trying to make me feel more useless than I already felt."

This young woman wanted to work and be part of 'mainstream' society. Instead of engaging with her hopes and her strengths, it would appear that the psychiatrist's interventions were designed to label her as 'sick' and helpless, working to a deficiency model. Any sense of her own autonomy or agency seemed to be removed from her by this approach. She was also angry about being labelled and resisted this by saying:

"He [psychiatrist] said I had manic depression or something like that. I said if he called me schizophrenic I'd stick a fork in his head, so he didn't."

Clearly, her resistance to being labelled could easily then be interpreted as further evidence of her 'madness'. As she saw it:

"I'm not crazy, it's the world that's crazy."

Annoyance at being labelled was also present in another of the survivor's accounts who felt dismissed and misunderstood when she was told (or what she remembered being told) she had a "disturbed personality" by her psychiatrist. She then decided not to go to see the psychiatrist again.

These accounts articulate the need for working in a way which recognises and values peoples strengths, that resists labelling and that works with an understanding of distress rather than the symptoms of distress. All these approaches would be valued by these survivors (and very likely other service users too).

4.12.4 Medication

Views about medication were mixed. A couple of survivors resisted medication as they did not feel it would be helpful and they were worried about the side effects. Others felt that medication helped in some ways.

“I get a lot help from my current GP and I have anti depressants. I feel I need them... because I have a lot of problems and worry, at least with the tablets I feel a little peace of mind. Although I know that the peace of mind isn't real.”

And another survivor:

“So I was only young and I'd never known about anti-depressants so I started to take them and you know like when you're on medication sometimes it does make people better and it did make me better in a way, but I was like a zombie. I felt like a zombie with it.”

As the interview progressed, it emerged that the survivor both valued the sedative effects of her medication as she:

“... could be asleep and that's how I preferred to be at that time, I wanted to be asleep you know, away from the world just on my own, just fast asleep in a world of my own and I just wanted to be left alone but then I started to put weight on with those tablets a lot of weight.”

But she also felt she “was wasting away”. So although she got some relief from the intensity of her feelings from her medication, the sense of wasting away and weight gain further fed into her sense of despair setting up a cycle that was difficult to break out of.

4.12.5 Police

Survivors' experiences of contact with the police have been varied, but unfortunately with more criticism and gaps being evident than examples of good practice.

To escape an abusive home environment, one of the survivors ran away with a younger sibling to the police station in the middle of the night as they did not know where else to go for help. They were in their early teens at the time and petrified. In this instance, much to their relief, the police contacted Social Services who placed them in foster care.

In another of the accounts, had been beaten very viciously by her father, resulting in serious injuries. Despite the many bruises evident on the survivor who was 14 years old at the time, the police took no action. This was clearly a child protection issues which ought to have been followed up.

“I referred myself to Social Services. The police left the same night, saying don’t waste our time. I went after school and said I’m not going back home.”

Social services placed her in foster care.

Another of the survivors contacted the police after many incidents of violence towards her by her husband. She had taken a big risk in contacting the police and asking them to come to her house. In her words, she felt “betrayed” by them. Firstly, she was not given privacy in which to discuss matters – so she could not tell them the full story. Secondly, she felt one of the police officers made racist comments towards her, and, thirdly, they said they could offer no help except for a social work telephone number which she could contact after the weekend. She was terrified of the consequences of having broken her silence and now had the whole weekend ahead of her with the very real threat of further violence. As it turned out, even the telephone number she was given was the wrong number.

4.12.6 Refuges

Views about women’s refuges were the most positive as illustrated below.

“... refuge is a place of safety, not on the streets, feeling secure, [help with] money matters. I thank them a lot for helping me out. They’re doing a great job for people like me.”

“The refuge tried their best. My key worker is always there and she’s helpful and practical. She tries to increase my confidence. They try really hard...and I feel safe.”

In addition to a place of safety, survivors also greatly value emotional support and understanding:

“It’s [refuge] very welcoming. It’s not just a case of Asian [workers], you want someone to be there for you emotionally cos you’re scared, hurt, low, disturbed, upset, depressed. You want them to listen to you from the heart, not just for the sake of it. They should help you from the heart, they should talk to you emotionally way, ‘cos that’s what you need. You’re not just some wierdo on the run.”

Indeed, the only criticism made of refuge workers by one of the survivors, was their need to fill in forms and inform new residents of the house rules etc prior to listening to the woman’s story. This emphasises the importance attached to emotional support.

It can therefore be concluded that service interventions which engage both with the practical (e.g. housing, benefits etc) as well as emotional support are well received by survivors. Significantly, the South Asian women’s refuge also makes efforts to work with women who have no recourse to public funds because of their immigration status.

4.13 Meanings and Feelings: Suicide and Self-harm

As the evidence presented throughout the discussion above illustrates, the causes of mental distress for South Asian women are complex and inter-related and more to do with the oppressive contexts within which women are situated rather than individual pathology. Clearly this does not invalidate or marginalise individual experiences of distress and it is to the meanings and feelings associated with suicide and self-harm that we attend to next.

4.13.1 Build up of feelings

For all the survivors interviewed, there was a recognition of an escalation or build up of emotion relating to their particular situations. Some survivors linked their feelings to childhood sexual abuse which although had had a profound impact, was overtaken by further abuse which was more current and discussed more fully in the research interview.

“From the age of 5 I wasn’t happy with my family and the way things were cos my dad tried to [sexually] abuse me. So from that age, I had the fear inside me, I had to get away, but I couldn’t.”

Other survivors reported positive childhood experiences and linked their distress to marriage.

“He [husband] wasn’t treating me well. He used to beat me and trouble me. I couldn’t sleep or eat properly. I was getting very tired with the housework, but I couldn’t sleep... I was very worried, it felt like my whole body used to ache.”

“ Took a long time for me to realise that I wasn’t very well. I wouldn’t wake up in the morning, I’d stay in bed till about 4 o’clock and I’d be crying all the time and eating like chocolates and sweets all the time as well and that wasn’t like me and then I started to put weight on and then I got more depressed because I thought I looked really fat. And I wouldn’t meet people anymore, I’d stay upstairs and lock my room door all day long and feel scared every time the phone rang or anyone wanted to see me. That was after I got married. So it started after that. ...”

4.13.2 Trigger points

5 out of the 7 survivors interviewed were women who attempted suicide as they felt completely trapped by their circumstances and felt the only ‘freedom’ would be to not exist in this world. The other two survivors self-harmed and had also attempted suicide. To quote one of the workers interviewed, the “emotional territory” between self-harm and attempted suicide appeared to be very similar in many respects. As one of the survivors put it:

“There is no difference really, when I’m harming myself sometimes, I do feel like I want to die as well.”

Feeling scared, alone, hurt, betrayed, alongside thoughts about self-harm or suicide although present for some time were often intensified by a ‘trigger’ event which precipitated a suicide attempt or self-harm. So, for example, one of the survivors who had been in a violent marital relationship, felt the last straw was when she was slapped and beaten in front of her in-laws, who did nothing to help her. Hence this very public humiliation increased her sense of shame and isolation as nobody else seemed bothered by her abuse. For another survivor there had been many issues including the loss of her mother and emotional abuse within her second marriage. However, her sense of isolation, loss, abandonment and betrayal magnified significantly after a relationship breakdown with her substitute mother figure, at which point she felt:

“I’d had enough and I felt desperately lonely, really felt it was the end. I wanted to ram the car into the wall and just wished somebody would crash into me. I felt so desperate that I didn’t even think about my [child].”

What came over most strongly in all the accounts was the sense of desperation and urgency to end the misery either temporarily or more permanently.

“It’s like something comes into you, You don’t feel scared of killing yourself you get so fed up, so much abused, you don’t care about anything, how much you’re going to hurt yourself. There have been times I would have liked to stab myself but they’d hidden all the knives. I was craving for a knife to put inside me just wanted to finish myself – no other way out. I was always thinking about killing myself, feeling I had to. It was like I was in hell.”

4.13.3 Power and control

The lack of fear in hurting oneself was also evident in other survivor accounts and appeared to be linked in some ways to experiencing a sense of power and control, normally not available to them.

“I’m not scared to die or to hurt myself, I never think or plan it, just do it.....it [self-harming] does have the power to make all the pain stop.”

“...it [self-harming] was a way of feeling pain and anger, every time I hurt myself, I felt better.”

“I felt strong cos I’m in control, I know I could do it [kill myself]

4.13.4 Regrets

Together with the sense of power and control to end their lives or to hurt themselves, also came a contradictory set of feelings: guilt, fear and regret.

“...so I went and told my mum I said I’ve taken these paracetamols now and I feel really scared because I thought I was going to die and then I was really scared and regretted it”

“ I felt so alone and scared, suicide would help me get away. Sometimes I feel angry with myself..... thank God I’m not dead”.

“I can’t believe that I didn’t think about my son. I’m shocked with myself I felt I did wrong, [to attempt suicide] but I’ve got to move on”

For many, (but not all) of the survivors being alive today was a matter of relief and this demonstrates the need to ensure that suicide prevention is taken seriously and that such services are provided in a sensitive manner. Discussion of what these survivors would have found helpful at the time of their suicide attempts is discussed later.

4.13.5 Self-harm as self-punishment

For the women who self-harmed, self-harm was seen both as a coping mechanism but also as a way of punishing themselves as they blamed themselves for being ‘bad’.

“I don’t know how to cope with them [problems] and I just think self-harm is the best way because I feel like it’s my fault, so I should be the one suffering... [I] do stupid things to me, make myself feel bad until I feel like I’ve punished myself enough.”

The theme of punishment and self-blame was also present in the following:

“He used to beat me, punch me, throw me on to the floor and kick me. it was a relief that he beat me, so the pain came out and I didn’t have to hurt myself.”

This statement implies that the violence even when not self-inflicted serves to fulfil some of the functions of self-harm. Clearly this should not be read as women ‘asking for violence’ or to minimise in any sense the impact of violence on women, but to understand the different meanings self-harm has for different people at particular times. This survivor has since left her abusive relationship

4.13.6 Turning the Corner?

Some of the survivors felt that their suicide attempts or self-harming were behind them, although others felt these were still options open to them.

“Now no one is abusing me, using me, I’m in control now, so why should I kill myself? cos I’ve got control.”

“...pain’s still there, but I’ve realised that hurting myself isn’t the answer now.”

4.14 Responses to Attempted Suicide/Self-harm from Families and Staff

The suicide attempts and self-harm were perceived by survivors as a way of resisting, coping with or escaping intolerable circumstances. For those for whom suicide was a last resort to escape the brutality, the treatment they received after their suicide attempts makes depressing reading.

4.14.1 Yet More Punishment

Survivors found that their families’ responses after their suicide attempts or self-harming to be very punitive and uncaring. This was mirrored for some survivors in the attitudes of mental health workers. A common response from family members was anger, which often turned to violence.

“He beat me so hard when he [husband] found out [that she had taken tablets] that I was sick and the tablets came out. Then he got very angry, he thought I was trying to put him in jail. I explained that I wasn’t, I was trying to kill myself.”

“They would tell me off because it’s against the religion.....or else dad would persuade me to take more [tablets etc]. Then he’d beat me.”

“It was just more shit when I came home [from hospital]. They [in-laws] tried to snatch my daughter away from me. They don’t care, my husband hit me the same day.”

“They [family] battered me for trying to kill myself saying I had no right to kill myself. I had no control in killing myself, they took the right away from me. I hadn’t the right over myself. They said you’re going to do whatever we say.”

This spells out very clearly the further risks to the women of sending them back home with family members without a proper risk assessment. Risk assessments at A&E departments need to be thoroughly carried out with due regard to the sort of ‘care’ these women are going

to receive within the family. Idealised notions of strong family values in South Asian cultures need to be tempered by an understanding that families can also be a site of oppression for women – just as white families are.

An alternative to violence to attempted suicide or self-harm was:

“My family just ignored it [self-harm]or thought I was mad. Nobody took notice.”

The dismissing of what the suicide attempt or self-harm was trying to convey was also noticeable in the responses of mental health staff. One survivor was asked by a nurse in hospital why she had tried to kill herself. However, this was asked in a public arena, with other staff wandering past and the nurse was sitting in front a computer. The overall impression the survivor got was that the nurse had not really wanted to know what was going on for the survivor. Hence the survivor responded with :

“I was having a bad day – don’t you ever have them?”

Another survivor talked of feeling very judged by her social worker after a suicide attempt who said,

“You shouldn’t have done that [attempted suicide]”

Two of the survivors were supported by their families. One of the survivors above, was supported by her brother, who she described as ‘giving [her] new life’. Another survivor talked of the immediate response of her family as being supportive, but that it was short-lived.

Indicators of Good Practice

- Non-judgemental approaches
- Privacy and engagement with the service user
- Risk assessments which assess for likelihood of further violence
- Ensuring that assessments do not use cultural stereotypes
- Talking confidentially with the survivor, ensuring an independent interpreter is used where necessary

4.14.2 The Importance of Understanding

Running through the thread of the discussions, (as evidenced above as well) both explicitly and implicitly, was the strong feeling of survivors that they were not ‘heard’ or understood,

either by their families or by mental health workers.

In the context of her family, this survivor said:

“It was a really really bad experience and nobody was listening to me, nobody wanted to know what was happening..... to understand yeah what I was going through because nobody seemed to understand what I was going through, nobody did. And then one day after that I took an overdose.”

And in relation to her mental health worker:

“I was very very low at the time and I had somebody helping me from [name of mental health agency] but she wasn’t much of a help to be honest. I don’t like saying that she wasn’t much help, but at the time she wasn’t, she wouldn’t even listen to me, nobody would listen to me.”

Another survivor commented powerfully on the lack of understanding and consideration shown to her. She had already had one attempt at suicide.

“My mum’s respect is at stake, so they wanted me to go back to [name of country], so I thought what about mine [my respect]? What about my life? Have you thought anything about me? Have you ever asked me how I’m feeling?”

And another survivor after her suicide attempt:

“When I did something so drastic, I’m crying for help, but they still didn’t really understand.”

The theme of lack of understanding was also illustrated in service users’ experiences of services and in the judgemental attitudes of some mental health workers (see worker discussions). These accounts alert us to the need to attend to the business of understanding – a quality that many mental health workers may mistakenly take for granted. It is therefore not surprising that, in terms of services, what survivors think would better support them are workers who are more understanding and who have time for them. Alongside this, the intensity of feelings of isolation and aloneness around the time of attempted suicide, also indicate the important role of a supportive relationship.

For some survivors, ‘race’ and ‘gender’ were seen as significant attributes, facilitating understanding on assumed commonalities of experience based on ‘culture’, religion, and gender. For others, this was not a pre-requisite, therefore stressing the importance of both South Asian women workers and the need for white workers to work inter-culturally (see ‘matching’ in worker discussions). Hence this survivor said of her white, male worker:

“... he put more heart into his work, he was genuine. I felt [name of worker] cared about me.

He never needed an excuse to come and see me.

But also:

“For a woman to be understood, I think it would take another woman. That’s the only way I feel I would be understood and accepted. In relation to ‘race’ and culture her response was :

“I think it [similarities in culture] would help cos my culture isn’t the same as western.”

For other survivors, having contact with workers who had experienced mental health problems was very important as was the support gained from other people who had been through similar experiences.

“A person to talk to who had been through the same, not exactly the same, but someone whose experienced the pain, someone who has been through suicide.”

When asked what kind of services may be helpful to other South Asian women who had experienced suicidal feelings and had attempted suicide, this survivor suggested:

Survivor: “I think what would be helpful would be to be able to talk about, for each of them talk about their experiences with other people.

KC: “So in a group?”

Survivor: “Yes, in a group because that would make them feel that they aren’t the only ones, there’s other people there that have been through those things as well and it would make them feel more confident, because I think that a lot of Asian women lack confidence because of the you know these things like divorce, it holds a stigma doesn’t it? people don’t like divorce but they don’t think that people have to have a divorce with what they’re going through, so they need to be able to talk to people about it, I think that will help.”

Survivors’ self-help groups therefore emerged as a potential source of help and many survivors felt that these should be developed.

In terms of other service interventions which they had not necessarily been offered, but which were perceived as helpful included counselling (in first language rather than through interpreters), massage and aroma therapy. Other ideas for reaching South Asian women included better publicity of services and a telephone help line. However, these interventions also need to be developed within the overall context of systemic issues such as immigration, housing, poverty, sexism and racism as has been clearly identified in the survivor accounts.

Indicators of Good Practice

- Assertive suicide prevention policy to include women who are not currently part of mainstream provision
- Increased ability to empathise with South Asian women attempting suicide/self-harm
- Ensuring continuity and availability of staff time when service users are in crises
- Maintaining a relationship when service users are vulnerable
- Choice of worker re: gender, ethnicity etc to rest with service users
- A range of service options including survivor groups, counselling, complementary therapies and telephone help line
- Campaigning and advocacy on issues such as immigration, housing, poverty etc
- 'Safe' housing other than refuges

4.15 Survivors' Strengths and Coping Mechanisms

This chapter would not be complete without recognising the many strategies of survival that the women have used (other than attempting suicide and self-harm). Coping mechanisms mentioned included: religion and spirituality, writing, dancing, education, a close and loving relationship, talking to others.

4.15.1 Religion and Spirituality

Most of the survivors felt that religion had been an important source of strength and comfort for them. Significantly, this was now solely in the private sphere and included reading of the Koran, prayers, meditation and a strong faith that Allah was watching over them.

"Then [when pregnant] I stopped thinking about dying, I would be killing that baby as well. I thought it's not fair, there has to be some God, some Allah to help me, I've got to hold on."

Another survivor, subject to the "one year rule" was still fighting, four years after coming to England:

"I believe in my faith completely. Allah gave me the strength to fight – even though my husband wrote to the Home office and asked them to send me back as the marriage had broken down. He also wrote to them saying that I was a danger to him."

One survivor's critical understanding of Islam in relation to women enabled her to hold on to her faith and to see herself as worthy of respect. Clearly, the role of religion in this context

can be seen as a 'protective' factor. However, significantly, this is not to be confused with the 'organised' aspects of religion – or even other forms of community organisation, which one survivor described as:

"...that hurts more because your own community, your own colour, your own caste won't help you. They should be helping you, they talk all Islam, but no-one... These religious people are a disgrace...Community? It's just a name, a label. How could anyone help abuse, how can we have a [family] meeting and emotionally they can't help you."

From the above, the implications for working with 'communities' or 'conservative' community groups are clear, in that they are unlikely to be able to attend adequately to the needs of women experiencing abuse where this challenges traditional family structures and relationships (see worker discussions for a fuller discussion on South Asian community groups).

4.15.2 Writing

Many survivors used writing as a way of releasing and externalising their feelings.

"...write up things, I'd write, I'd be on the computer going mad, typing away, typing away, but I wouldn't go back and read it. It was my true deep feelings."

In contrast to this very private act of writing, another survivor wrote poetry about her experiences and feelings which she was comfortable to share with others.

4.15.3 'Keeping Busy' and Feeling Needed

Most of the survivors talked of the need to be busy and occupied as a way of keeping painful thoughts and feelings at bay. This included a range of activities for example: going to college, caring responsibilities, voluntary work, beauty and fashion, and dancing. Significantly, other than diverting unwanted feelings, these activities also took on a momentum of their own, helping to increase confidence and feeling valued.

4.15.4 Close relationships

What was spoken about most poignantly was the centrality of close, loving relationships, particularly with their children. For some survivors there was a strong desire to protect their children from the sort of experiences they had endured. At a different level, the child/children represented a sense of deep connection to another individual, hope and a purpose in life.

"For her, I'm living, otherwise I would have killed myself. However she's come she's come

and she needs you.... Allah has given me a gift to hold on to, to live on, cos I deserve to be happy, like your own gold. Gives me something to do, I've got a purpose. They're [the abusers] winning in a way if I kill myself – I want to show them you've used and abused me, but I'm going to carry on."

Survivors who had children at the time of their suicide attempts felt angry, shocked and guilty that this had not stopped them at the time. However, in kinder moments to themselves, they also recognised the distress they must have been in to contemplate suicide and to act upon it. Since her suicide attempt, this survivor spoke about her relationship with her son as:

"...the biggest thing is my son – he's kept me going. He's [God] put my son into my life. I can't do it [commit suicide] because of my son. He's the only thing that will stop me."

And:

"You [her child] are the star of my life – I breathe because of you and I breathe for you."

Another survivor had taken on caring responsibilities for family members very willingly as she felt these responsibilities had given her a sense of purpose.

"I give myself a lot of strength. I feel happy that I can help my father and brother."

Not only do these accounts highlight the enormous importance of close and loving relationships, but also presents an alternative view to some of the analyses of middle class western feminism where the role of women as carers is often evaluated negatively as the focus of these feminisms is in the 'paid' workplace. Hence concentration on issues such as child-care, progression of women into management, 'glass ceilings' etc tend to marginalise or overlook the concerns of women who are in different contexts. The accounts in this study clearly demonstrate that at this point in time, caring responsibilities are crucial to the women's survival and an important coping and protective mechanism. In saying this, it is not being intimated that the role of women, especially South Asian women is in the home, but rather to recognise the diversity of experience and meaning attached to 'caring'.

What is very evident in these survivor accounts, is that far from the usual construction of South Asian women as passive and accepting of oppression, these women have fought and survived systems of oppression based on class, racism and sexism and have also challenged cultural norms of South Asian communities at great emotional (and often physical) risk to themselves. Furthermore, they have often achieved this despite the general lack of care and consideration shown to them by 'helping' agencies.

4.16 Summary

Within this study, a range of inter linking factors were mentioned by South Asian women as contributing to their suicide attempts and self-harming. These were: sexual and physical abuse, domestic violence, immigration issues, forced marriages, racism, and issues of loss. Issues that were closely allied and generated a lot of stress included poverty and homelessness.

The age range of survivors interviewed was from 17 years to 30 years. The most common method used for suicide attempts was through overdosing although other methods were also used: hanging and slashing of wrists. Those who self-harmed cut themselves, used burning, drank substances such as bleach or head lice shampoo, or misused substances including food, alcohol and illegal drugs. Significantly, three of the survivors either attempted suicide or started self-harming in their early teens and five of the survivors had attempted suicide more than once.

A key theme clearly emerging from the survivor accounts are the links between domestic violence in particular, and attempted suicide and self-harm, as all but one of the survivors interviewed had experienced domestic violence. Whereas the generalities of domestic violence and commonalities with white women's experiences are important, the specificities of South Asian women's experiences of domestic violence also need to be attended to. Hence considerations and understandings of domestic violence and distress also need to be located within the context of racist housing policy, racial harassment, immigration, as well as cultural concepts such as honour and shame.

In terms of specificities of experience, the smallness of South Asian community networks makes it very easy to locate South Asian women who have escaped violent relationships and thus speed of response in housing matters is crucial. Survivor accounts also highlight how many South Asian women feel safer in a different town or city from that of their abusive partner/family. However, there are also costs, as in so doing, the woman may well come to a place where she has no connections, friends or family. Moreover, in the search for 'invisibility' within South Asian communities, survivors may chose to live in a white area in which they are very 'visible' and therefore vulnerable to racial harassment and attack. These threads in the survivor accounts illustrate how difficult it is for South Asian women to find a 'safe' place.

These strategies for survival clearly also have implications for how accessible 'traditional' South Asian community organisations may be to such women and particular significance for those mainstream organisations who may feel that due to smallness of numbers of South Asian people in their localities, they do not need to provide services to this group.

The arrangement between the 'private club' (white, racist state patriarchy) and its 'gatekeeper' (South Asian patriarchy) gives rise to the potential for the exploitation and abuse of women as evidenced particularly in one of the survivor accounts in relation to the "one year rule."

As illustrated, the state can be seen to be an active partner in the violence against women. Despite recent concessions to the one year rule, it is unlikely that this will make any material difference to South Asian women in this situation. The evidence also illustrated how the key principle in welfare policies of the 'safety net' does not apply to this group as they have no recourse to public funds. Central to this analysis are the concepts of the shifting and different 'public' and 'private' spaces available to citizens and non-citizens.

Survivors had come into contact with a wide range of agencies including: social services, education, police, housing and benefits agencies, primary and secondary level health care, specialist mental health services and women's refuges. Survivors' experiences of these agencies, points not only to a failure of a wide range of services in meeting the needs of South Asian women, but also how services often (unwittingly?) put them at further risk. The evidence also indicates that South Asian women's first contact with services is when they are in crises, rather than at earlier, less acute points. The main service sector that was viewed positively by survivors were women's refuges. It can therefore be concluded that service interventions which engage both with the practical (e.g. housing, benefits etc) as well as emotional support are well received by survivors. Significantly, the South Asian women's refuge also makes efforts to work with women who have no recourse to public funds because of their immigration status.

The analysis then moved on to consider individual experiences of distress and the meanings and feelings associated with suicide and self-harm. For all the survivors interviewed, there was a recognition of an escalation or build up of emotion relating to their particular situations. Feeling scared, alone, hurt, betrayed, alongside thoughts about self-harm or suicide, although present for some time were often intensified by a 'trigger' event which precipitated a suicide attempt or self-harm. The lack of fear in hurting oneself was also evident and appeared to be linked in some ways to experiencing a sense of power and control, normally not available to them. Together with the sense of power and control to end their lives or to hurt themselves, also came a contradictory set of feelings: guilt, fear and regret. For the women who self-harmed, self-harm was seen both as a coping mechanism but also as a way of punishing themselves as they blamed themselves for being 'bad'.

Most survivors found their families' responses after their suicide attempts or self-harming to be very punitive and uncaring. This was mirrored for many survivors in the attitudes of mental health workers and in the failures of services as outlined above. Firstly, it is urged that risk assessments in various settings, but particularly in A&E departments, need to give due regard to the sort of 'care' women are going to receive within the family. Idealised notions of strong family values in South Asian cultures need to be tempered by an understanding that families can also be a site of oppression for women – just as white families are. Second, the strong feeling of survivors that they were not 'heard' or understood, either by their families or by mental health workers, alerts us to the need to attend to the business of understanding – a quality that many mental health workers (and their managers) may mistakenly take for granted. It is therefore not surprising that in terms of services, what survivors think would

better support them are workers who are more understanding and who have time for them. Third, the accounts also articulate the need for working in a way which recognises and values people's strengths, that resists labelling, and that works with an understanding of distress rather than solely with the symptoms of distress.

Survivors' groups emerged as a potential source of help and many survivors felt that these should be developed. In terms of other service interventions which they had not necessarily been offered, but which were perceived as potentially helpful, these included counselling (in first language rather than through interpreters), massage, aroma therapy and other complementary therapies. Other ideas for reaching South Asian women included better publicity of services, community education and a telephone help line. However, these interventions also need to be developed within the overall context of systemic issues such as immigration, housing, poverty, sexism and racism as has also been clearly identified in the survivor accounts.

What is very evident in these survivor accounts, is that far from the usual construction of South Asian women as passive and accepting of oppression, these women have fought and survived systems of oppression based on class, racism and sexism and have also challenged cultural norms of South Asian communities at great emotional (and often physical) risk to themselves. Furthermore, they have often achieved this despite the general lack of care and consideration shown to them by 'helping' agencies.

5 COMMUNITY PERSPECTIVES

5.1 Background

The research described in this section is a collaboration between the Asian Women Attempted Self Harm and Suicide Health Action Zone (HAZ) project and the Mental Health Needs Assessment (MHNA)/Commissioning Project. This section represents one aspect of the broader HAZ research project and the MHNA research. Colsom Bashir (MHNA project) and Khatidja Chantler (HAZ project) designed the research methods and semi structured interview themes. This segment of the research was conducted and authored by Colsom Bashir.

The MHNA/Commissioning Project was funded by Manchester Health Authority in June 2000 and involves a partnership between Central Manchester Primary Care Trust, Manchester Mental Health Partnership and the University of Manchester. The Project aims are to conduct a mental health needs assessment across Central Manchester Primary Care Trust for people experiencing mild to moderate mental health problems.

5.1.1 Aims

The aims of the Community Perspectives aspect of the study were to ascertain the perspectives of South Asian communities as expressed by Asian women's groups to better understand how issues of suicide, self harm, and mental health were viewed and to explore issues around support and service provision.

5.2 Methodology

5.2.1 Research, Design and Groups

The original HAZ research design proposed four focus group discussions with Asian women's groups across the Health Action Zone area. The decision to contact women's groups was made to ensure that voices frequently marginalised and unspoken were given space, since the majority of community consultations involve community "leaders" - normally men. This pertained to two groups in Manchester, one in Salford and one in Trafford. The aim was to organise groups of between 5 to 10 women each, with an attempt to reflect the diversity of South Asian communities in the makeup of groups.

In order to elicit the necessary information semi structured group discussions were deemed an appropriate method. Researchers (e.g. Reinharz, 1992) examining women's experiences

have considered qualitative research methods as most effective in unraveling the intricate layers of women's experiences. In relation to Black women, Essed (1994) noted that the study of a selected sample is useful as a methodology for the analysis of multiple sites and dimensions of experience, oppression and resistance which would be difficult to analyse using other methods of research.

The semi structured group discussion content was reached by negotiation between the two collaborating projects. The following 4 topics were finally decided upon to generate the focus group discussions:

- Understanding of mental distress, suicide and self-harm
- Factors contributing to South Asian women's experiences of attempted suicide and self-harm.
- Community support
- Service provision

5.2.2 Procedure for Identifying and setting up the Groups

Focus groups were set up via existing community projects that organised Asian Women's groups. The researchers had worked in the Health Action Zone area prior to conducting this study and so were able to establish a list of groups to approach to participate in the research. There were a number of attempts to contact the following projects to either find out about current groups that were running or for further information:

- Asian Women's Self Help Group
- Bangladeshi Women's Project
- 42nd Street - Suicide and Self Harm Project
- Hosla - Asian Women's Outreach Project
- Indian Senior Citizen's Centre
- Neesa
- Pakistani Resource Centre
- Saheli Asian Women's Refuge
- Trafford Asian Women's Association
- Trafford Asian Women's Network
- Women's Domestic Violence Helpline - Manchester
- Women Working Together - Salford Community Health Project

Initial contacts were made with groups in January 2001. Due to the time of year, and lack of time and resources for both organisations and researchers, the 4 focus group interviews were eventually conducted with the following projects who were able to set up focus groups fairly rapidly.

- Saheli Asian Women's Refuge Residents Group (5 women - age range: 19 to 33 years)
- 42nd Street - Young women's group (7 women - age range 17 to 22 years)
- Women Working Together - Salford Community Health Project (7 women - age range 22 to 45 years)
- The Bangladeshi Women's Project (12 women - age range 25 to 50 years)

5.2.2.1 Initial Meetings with Community Workers

Initial contact with community workers responsible for running groups took place by telephone followed by a meeting to discuss the research face to face. Face to face contact was considered to be the most efficient communication method due to the lack of privacy and limiting nature of telephone conversations, the amount of information to be communicated, the 'overuse' of user groups in research without any apparently useful outcomes, and the sensitive nature of the research. All of which needed to be explained effectively if community workers were going to be asked to release resources (time and space) for the research. Initial meetings were held with all participating projects apart from Salford Community Health Project who had already been made aware of the research by Khatidja Chantler. A lengthy initial meeting was held with the Indian Senior Citizen's Centre who were eventually unable to respond within the time frame partially due to the fact that the Indian earthquake in January 2001 had particularly affected this community.

The aim of the meeting with workers was to network, inform them about the collaborating research projects and explain the purpose, content and time required for the focus group discussions and describe potential outcomes of the research. As a result of initial meetings, dates and times were set for focus group discussions. Other community projects were unable to allocate resources to the research or were unable to respond within the specified time frame.

5.2.2.2 Issues that Arose out of Initial Meetings

The main issues that arose out of these preliminary meetings was a sense of confusion about the research, a concern about the seriousness and potentially upsetting nature of the area of discussion, and finally how the research would be used, if at all.

Consequently, an information sheet was drafted resembling an informal research contract, which would go some way to allaying the confusion and suspicion about researcher motives and research outcomes. The information sheet covered the following areas:

- Biography of the researcher including researcher's values, ethnicity and work experience.
- An emphasis on the researcher's personal recognition of the barriers to opening up during group discussions, including: a stranger asking questions; and a research project

asking questions that could create negative perceptions of Asian women or the Asian community.

- The organisation, purpose and content of the discussions and support agencies should difficult personal issues arise for individuals.
- A list of ground rules that included details of confidentiality, an emphasis that personal experiences were not a requisite of the research but rather that it was opinions that were being sought.

One key issue that arose out of discussion with the Project Manager of the Bangladeshi Women's Project was the need for an interpreter. The project manager, in the spirit of collaboration, organised the services of a qualified interpreter. A meeting was held with the interpreter for half an hour, immediately prior to the focus group discussion, to ensure she was briefed about the subject area and comfortable with her role in the research. This short briefing session covered the following points:

- Introduction to the research and facilitator background
- Information about the subject under discussion and a copy of the semi structured interview in English.
- Discussion on any problems she might have with the subject area or possible areas she might have difficulty interpreting.
- Facilitator expectations of what would be translated i.e. as close to everything as possible and especially the most obvious points.
- Focus group discussion protocol (see below).
- Remuneration arrangements.

5.2.3 Procedure for Facilitating Focus Groups

The 4 focus groups were facilitated, generally, in a similar way.

- The research context was explained once again reiterating what had been written on the information sheet in an attempt to minimise/allay any anxieties or suspicions the group might have.
- The group were given the opportunity to ask further questions or make comments on any of the information provided.
- The groups were invited to talk in Urdu, Hindi and Punjabi if they thought they could communicate their opinions easier, as the facilitator was able to understand these languages and could speak Urdu.
- The group members were informed that the facilitator would take notes and that they should continue with the discussion and try not to be put off by this.

The 42nd Street group interview was facilitated and fed back in English. At the Saheli interview the facilitator generally asked questions in English but the discussion took place in

Urdu, English and Punjabi. The Salford group was facilitated in English and Urdu. An interpreter was used with the Bangladeshi Women's Project.

The following protocol was agreed with the interpreter for the Bangladeshi Women's group.:

- The interview would be facilitated by the researcher.
- The interpreter would translate questions/comments of the facilitator and then when asked she would translate what was being said by group members or to specifically invite a group member who had not been heard during the discussion to talk further.
- The facilitator would address questions to the group directly to ensure engagement with them primarily, rather than with the interpreter.
- Generally, the facilitator would wait for natural breaks in the conversation unless something was said that provoked a strong response from other group members or stopped the flow of the discussion.

The facilitator began the group discussion by providing the following information:

- The high rates of suicide and self harm amongst young Asian Women
- The national guidelines that had emerged emphasising the need to address this issue.

The remainder of the discussion followed the 4 basic topic areas of the semi-structured interview. Although one discussion felt stilted as if the group were waiting for the next question, generally the discussion flowed naturally from theme to theme, with the need for supplementary questions to draw the group back when the discussion strayed too far from the research question. Quite often the women's conversations would cross over into another theme, which the facilitator explored as it arose rather than rigidly follow the interview outline in order to ensure continuity of engagement with the discussion.

5.3 Results and Discussion

The information from the interviews will be analysed under each topic identified in the semi-structured interview.

5.3.1 Theme 1: Understanding of the Terms

The first theme explored the groups' understanding of the concepts being used by the research. Specifically, the discussions explored women's definitions of mental distress and suicide and self-harm, as well as asking women to elaborate on what specific behaviours constituted self-harm or attempted suicide.

5.3.1.1 Mental Distress as a Symptom of External Pressures

The Bangladeshi Women's Group (BWG) and the Salford Women's Group provided examples of external and practical pressures that might be perceived as causal factors rather than specific symptoms of mental distress.

Examples included expectations of life or marriage not being met, not being able to speak the language, not having anyone independent to talk to, being short of money and needing to send money to families back home in Pakistan, missing family or home, getting blamed for any disgrace or shame the family experienced, domestic violence, and fear of racism and crime living in Manchester. The Salford women's group talked at length about the magnification of symptoms of isolation in relation to fear of crime and racist attack if they left the house. This should alert us to attending to the needs of South Asian women who may at one and the same time be very 'visible' in predominantly 'white' areas, yet rendered 'invisible' to service providers because they make up a small percentage of the population.

Whilst all the groups responded to the question, only the Saheli and BWG, connected the issues directly to their own communities or themselves. The 42nd Street, Saheli and Salford Group initially responded with their stereotyped perceptions of 'mad' people as perpetuated in the media. However, with further clarification and prompting about their knowledge of Asian communities the discussion focused specifically on experience or knowledge of mental distress within the Asian community.

Overall, mental distress was considered to result from systemic issues and a fundamental sense of isolation as a consequence of not being able to or not having the opportunity to speak of external pressures, or lack of support both within and outside the community. At some level the groups verbalised their recognition of how lack of social support led to a depletion of personal and psychological resources, including coping mechanisms, whilst a small proportion voiced the opinion that women should have the 'mental strength' to carry on through adverse pressures despite external circumstances.

The 42nd Street group and the Saheli group, which had the youngest age profiles, referred directly to mental health concepts or symptoms. These included: depression, sadness, breakdown, anger or having a short fuse, mood swings, talking to yourself, hurting others, abusing others, constantly thinking about all the pressures on you. However, once again both groups placed these symptoms of mental distress in the context of external pressures such as isolation, lack of support, bringing up children, not talking or having anyone to talk to, not having the mental strength to cope with pressures, and domestic violence.

5.3.1.2 Attempted Suicide and Self Harm as a Response to Social Isolation

The more specific question about understanding of the terms suicide and self-harm also

prompted groups to respond with causal factors. The Salford and 42nd Street group both agreed they had not heard of this being a problem in the Asian community. However, at the same time, the Salford group came up with the most examples of women they had actually known of, in the community, who had attempted suicide. Nevertheless with further prompting the 42nd Street, Salford and Bangladeshi Women's Group responded with a list of external pressures including: problems at school, bullying including racist bullying, forced marriage, domestic violence, migration and loss of culture and family, problems with in laws, children, health, not having anyone to turn to apart from a husband, and not being able to tolerate any more. Many of these are systemic issues, thus reinforcing the view that oppressive systems contribute to mental distress as is also evidenced in the survivor accounts. The groups again recognised the depletion of personal and psychological resources as a result of external pressures coupled with lack of social support.

The 42nd Street group referred directly to feelings associated with self-harm such as hating yourself, putting yourself down, not speaking to anyone and bottling everything up. All groups provided concrete examples of what kind of specific behaviours constitute self-harm and attempted suicide and a number of women stated they were talking from personal experience. Behaviours mentioned included: overdose, overeating, under-eating, cutting, hitting, slashing, drinking bleach, eating rat poison, drug taking, hanging, setting yourself on fire, lack of interest in children.

5.3.2 Theme 2: Factors Contributing to Suicide and Self Harm Attempts

The second theme explored experiences Asian women might encounter that would lead to suicide attempts and self-harm. Additionally, each group was asked to discuss whether different Asian communities had similar experiences. This theme generated more energetic discussion within the groups, than the first one.

In addition to the systemic issues outlined above, the Saheli residents' group talked about personal experiences passionately, with anger and sadness. Their experiences were very current because they had left their families and were taking refuge for precisely the reasons that women might attempt suicide or self-harm. Each of the women had some kind of personal experience of either attempted suicide or self-harm. They felt they did not have: anywhere to turn, anyone to listen to them, anyone to love them and see them as individuals outside of being an Asian woman, both within and outside the community. This provides further evidence of the links between domestic violence and attempted suicide and self harm as also articulated in the survivor accounts.

5.3.2.1 Izzat

All of the women's groups referred to the concept of 'izzat' (honour/respect) as a major

influence in Asian family life. The groups proposed that in some families 'izzat' was given precedence or preference over care for happiness of children. The groups also theorised that izzat could be misused to reinforce women's roles in family life, often to coerce women into remaining silent about problems. Izzat was described as all pervasive, internalised and reinforced by women too; preventing other community members from listening and getting involved. The groups thought that the burden of a family's izzat was unequally placed upon the women of the family. This created hard-to-achieve high expectations of women as daughters, daughters in law, sisters, wives and mothers and in 'problem' families led to strict and tightly controlled lives. The length a family might go to protect their izzat to the cost of individual women's circumstances also depended on how much they adhered to the concept of izzat and how they defined izzat. Izzat could be defined as family or personal honour/respect or as status and prestige in the eyes of the community. In addition, all the groups strongly stated that Islam was used wrongly by the community to emphasise stereotyped women's roles when in fact the Quran did not specify such negative treatment of women. The groups also agreed that the Western media reinforced this stereotype of Islam. South Asian women in these groups were therefore well aware of the dynamics of how 'race' and gender work together to further oppress them. The majority of participants recognised that oppressive practices against women also existed in 'Western' cultures and not just in the Asian culture as the 'constant hype about Asian women' proposed. This ties in with mainstream theories of the family, in its primary role of socialisation into class and gender identities in any male dominated environment, albeit experienced in a qualitatively different manner within Western, Eastern or other cultures (Mirza, 1997).

5.3.2.2 The Community Grapevine

Women from the Salford group talked about migration from Pakistan and how the pressure for families to be 'doing well' either according to the maintenance of cultural values, academically or with respect to employment, produced competition between South Asian families. One woman in the group talked about this being exacerbated for women because families struggled to get ahead in terms of education and employment in England. Another layer to the concept of izzat was the sense of competition it engendered between families each competing for status and prestige in the community. One factor adding to status and prestige of the family was the behaviour of the women and whether this was seen as 'good' behaviour according to community or religious values.

The group discussed how, as a result, a very efficient community grapevine had developed in community circles. This grapevine resulted in a phenomenal lack of privacy and space for women, and continuous 'gossip' or 'rumour' if any hint was seen of women behaving inappropriately. The fear of disclosure was expressed by all the women's groups. They strongly felt that if they ever discussed any personal issues or perhaps were even seen help-seeking this would get back to either their own families or others in their community somehow. One young woman talked about an experience of going to see the woman doctor at a practice and

how other Asian women there had remarked on why a young single woman should need to see a woman doctor without her mother. There was also mistrust of other Asian women from the community who might work as receptionists, practice managers or other staff in services they might access. Once again the lack of anyone trustworthy to talk to meant an increasing sense of isolation for Asian women. However, this should not be used as an excuse for mainstream services to neglect the needs of South Asian women, rather to recognise these as barriers to accessibility and work to overcome them.

5.3.2.3 Racism

Racism was raised as a problem during all the focus group discussions. Older women raised racism in relation to issues that their children faced at school, in education and employment. Younger women talked about racism in the context of their college experience where they reported being bullied or name called by white students or, when they wore Asian clothes, made fun of. Other women from the groups talked about crime and fear of crime when they went out and speculated that if a woman was experiencing stress at home coupled with fear of attack if she were to go out, this would increase her sense of isolation. Younger Asian women reported that the experience of racism from white friends who did not try to understand or listen to their predicament, and instead spoke from their own stereotypes of Asian and Muslim families, intensified their sense of isolation. The 42nd Street group mentioned that many white people adhered to popular stereotypes about Asian women, their culture and Islam, which increased women's sense of being lesser as Asians and Muslims outside of the community, as well as because of their gender in both realms. Some women and the Saheli group in particular, voiced their pride in their identity as Muslims and Asians, which they stated was in itself positively reinforced and encouraged within the family. The groups discussed how Asian women experienced disadvantage due to their gender within their families and communities but were at the same time affirmed in relation to their Asian-ness or religious identity. In contrast, outside their communities, in 'mainstream' life, they stated they were disadvantaged along lines of 'race' and gender. Therefore, being judged and experiencing unequal treatment was intrinsically linked to Asian women's experiences of racism and sexism.

5.3.2.4 Domestic Violence and Consequences of Leaving the Family

The context of marriage was seen to be a particularly vulnerable place for women, who were thought to be at risk of violence and abuse from husbands, in-laws, and family. Almost all of the groups talked about women experiencing marriage problems being the biggest factor in attempted suicide and self-harm.

The groups had strong opinions, particularly the Saheli group, about the position of 'in-between' they experienced, where they described how they were treated with contempt if they stood up to abusive families or if they took steps to leave, they were labelled as 'bad' by

the community, and judged and rejected by families. The group described how the consequences of this were immense because as single women/mothers they could not re-access a sense of community again. Some of this was confirmed by the Salford group of women who, at the start of the session, began 'gossiping' about 'bad' young girls who had run away for 'freedom' thus trivialising young women's experiences of abuse by perpetuating myths about why young Asian women leave families. The group described experiences of being taken advantage of once they had left home and theorised that this was because they were seen as Asian women on their own without family connections or anyone to 'care' for them, and therefore open to abuse and vulnerable from men particularly, of all backgrounds, who saw them as easy targets. Once independent in their own accommodation, Asian women's social support networks were depleted. Thus their sense of Asian-ness was no longer affirmed by a family and community network acting as a buffer, so everyday experiences of discrimination and racism intensified over time and as a result of separation. The Saheli group reported that as women they were in a no win situation outside and inside the community.

All of the groups expressed how being Asian meant they experienced sexism in a different way but that they did not think that white English women experienced less sexism, in fact the Salford group thought that white women experienced domestic violence more than other groups.

5.3.2.5 English Language Problems

All the groups agreed that if you were unable to speak English it would increase your sense of isolation, because it was likely to be directly linked with lack of knowledge of services and support, or knowing your rights (which might be deliberately held from you in an abusive situation). The Saheli and Salford group talked about the vulnerable position of women who had migrated for marriage purposes, being fearful of 'rocking the boat' in case they were sent back in shame to their families in Pakistan. The BWG talked about difficulties communicating with white professionals such as teachers or health visitors as a source of mental distress.

5.3.2.6 Other Issues

The group also listed a range of other factors leading to self-harm or attempted suicide including: lack of money or poverty; bringing up children alone; physical health problems; threats to or actually being forcefully taken to Pakistan; forced marriage, rape etc.

Some of the women, particularly the Salford group, talked about reasons for suicide as a judgement of personal strength or morality. For example, women attempting suicide did not have the will or courage; women could not manage their lives or themselves; they were disobedient; disrespectful of parents; wanted freedom/or a social life; were 'bad'. In many

ways, these opinions could be said to conform to mainstream psychiatry's views on what constitutes appropriate behaviour for women in particular (see for example Chesler, 1972). It also highlights the dangers of automatically assuming that a South Asian women's group would be supportive to a South Asian woman with experiences and feelings of suicide and self-harm. A reliance on 'cultural' factors alone is not sufficient as the Salford discussion illustrates; hence engaging with the complex and layered dynamics of community differences based also on gender and class inequalities is essential.

In an attempt to address why younger single women might self-harm or attempt suicide and to encourage discussion, particularly with the Salford and Saheli group (both of whom had focused on young women who were married), a supplementary question was put to all groups. The facilitator provided a hypothesis about whether sexual and other forms of abuse within the home from family members could contribute to attempted suicide or self harm. The groups were always silent in response to this and commented that they had never heard of child abuse within Asian families. There was some discussion in the Salford and Saheli group about whether this might definitely be an area women would remain silent about; one that they would not be able to talk about especially with other Asian women and even outsiders. Significantly, however, women interviewed within the survivor accounts did discuss personal experiences of abuse.

5.3.2.7 Differences within Communities

The majority of focus group participants were from a Pakistani background. One group was made up of Bangladeshi women and there was only one Indian participant. All except one Sikh woman were Muslims. The Saheli group suggested that all Asian women experienced similar problems regardless of country of origin or religion. They thought the issues were the same across communities. The 42nd Street group was silent and on prompting said they did not know (they were all Pakistani Muslims). They did guess that because there were so many different groups and factions experiences would vary but women would still be treated the same way.

The Salford group had a lengthy discussion about whether Sikh communities were more oppressive of women and Indian Hindu communities less oppressive. However, other group members who had not found this to be the case challenged this assumption. The group finally agreed that, depending on circumstances around settlement, different communities developed in different ways. E.g. if you were surrounded by other Asian families you were likely to be far stricter than if you were the only Asian family. Also the group decided that in different cities, Asian communities had developed in different ways. So, maybe the Pakistani community in Manchester was different to the one in Blackburn or Birmingham, which might correspond to differences in white communities in these areas, and there would also be socio-economic variations within the Asian community. The BWG commented here that they did not know about different communities but did mention that they thought that

Bangladeshi women might carry more family responsibility and were more likely to feel isolation because they could not communicate in English.

5.3.3 Theme 3: Support within the Community

This theme examined whether community support was available or effective or what the barriers were to getting support within the community.

All the groups generally said they thought that women would find it extremely difficult to access support within the community. Some of the women said they were lucky because they had supportive family members. The groups' comments suggested a general sense of fear and mistrust about talking to other people because of the community grapevine. The fear of being labelled, judged or blamed if women disclosed any family problems was paramount. The other issue was that if a competing family found out about a woman's problems the woman would be used as a weapon to disparage her own family.

Izzat, the groups reported, was used as the pivotal value by Asian communities when offering advice to women who did talk about what was going on. Izzat also led to reluctance on behalf of other families or individuals to get involved because they were fearful of being blamed or held responsible or of their own izzat being tainted if they got involved with another family's problems, according to the Saheli and Salford groups.

One of the women from the Salford group argued that whilst Pakistani culture had moved on since 'our Parents' generation had migrated from Pakistan, culture in some Asian families in Britain had remained static. She hypothesised that the Pakistani community here had held onto traditional value systems from 20 or 30 years ago when they emigrated because the culture had no influence here, was ignored or criticised by white people and therefore did not have opportunities to develop.

Other women said they would be reluctant to talk about problems because of the consequences. These included: disappointing parents; you would only get consolation from female friends but it would not solve anything; being called names or you would bring yourself into disrepute; being stereotyped or judged, being blamed for your own problems and taken to religious healers. Many of these views are not dissimilar to white women's experiences of taking the step to talk about difficult issues such as domestic violence and sexual abuse.

Some women said that no one was interested or wanted to ask about them in their own right. The only interest was in how they were perceived in the community or how they behaved.

The Saheli group talked about the importance of being around women of their own cultures and their pride in their culture and religion. They proposed that if they talked about their problems to non-Asians they were quite often met with further denigration of their culture

rather than being given support.

The BWG proposed that younger women were not bothered about the consequences because they had economic freedom so they would talk and challenge the community. Unlike the Salford group the women in the BWG were verbally more supportive of younger women who stepped out.

5.3.4 Theme 4: Service Provision

The final theme examined access to service provision and the barriers. It also explored the steps that could be taken to overcome barriers.

5.3.4.1 Access to Mainstream Service Provision

All of the groups initially said they would not be able to access mainstream service provision due to the fact that they would not be able to trust providers, they would need to know someone intimately if they were to trust them and once again there was a fear of the community grapevine. This signifies the enormous amount of work that needs to be carried out by 'helping' agencies to build trust with South Asian women.

In the event that a friend was feeling suicidal and needed help, and after further prompting, the 42nd Street group suggested GPs, Colleges, Youth workers, 42nd Street, and going to see a counsellor. However they identified barriers to accessing this support. They talked of how mainstream service providers were usually white and lacked understanding of the Asian culture. The women generally commented that white service providers had different values and experiences and would view Asian women's problems from their own 'white' experience. As a result, they might judge them as an Asian woman or respond by saying racist things about the Asian community or how extreme Muslims were; and they would offer simplistic sweeping solutions like leaving the family without understanding the complexities of their experience.

Barriers to accessing GPs were: it would go down on your record and you could have mortgage difficulties in the future; the GP might be your family GP and might tell your parents; and Practice staff or the GP might be part of the local community. In response to a prompt about telephone helplines women responded by saying if there were pressures at home this could make it worse because families might see numbers on the telephone bill. Additionally, women in those situations might not have money to use call boxes.

The BWG expressed similar mistrust about accessing mainstream agencies. The agencies they might suggest to people approaching them were: schools, Police, GPs. They said they would rather continue to feel cut off and isolated than talk to anyone and risk the

consequences. They would pray and use their faith to support themselves. However, they did feel that Bangladeshi women, who were outsiders to their community, presented less of a risk in terms of information filtering down the community grapevine but nevertheless they expressed how they still felt there to be a risk.

There was extensive discussion from the BWG about using interpreters. Quite often interpreters were unavailable or they feared a breach of confidentiality. The BWG argued that even their basic health needs were not fully met through interpreters - in terms of non-personal or private health matters they were okay. However in terms of 'women's sexual health, reproduction or family planning' they were loathe to speak in front of interpreters because it was too personal. They would not be able to talk about family problems with an interpreter there unless they were very desperate. Hence, the use of interpreters is clearly a second-best option and is not perceived to meet the health and social care needs of women who do not speak English.

The Saheli group, who was more experienced at accessing mainstream services, said once again they would find it extremely difficult to access services unless they were desperate and therefore not worried about the consequences. Again, there would be fear of gossip or the community grapevine. After being prompted they gave examples of services: colleges, GPs, social workers, the Police. However, there was a huge mistrust of these services because some of the women had already been betrayed by such services to families they were escaping from and stated that in the case of domestic violence breaches of confidentiality could prove fatal. This would therefore indicate that the myth of Asian families as all caring is probably being used to make risky assessments (see Worker Discussions in full report). Their most helpful experience so far had been at Saheli Asian Women's Refuge. This was echoed by the women interviewed for the survivor perspectives, further indicating the need to support and strengthen this type of provision as part of mental health services.

Telephone services were thought to be useful except that women might find it difficult to get privacy to use the telephone especially in abusive situations. Once again the issue of racism emerged and the women argued that white people had used them to confirm their own prejudices and they saw Islam as being devalued or stereotyped when they came out to white people as having problems.

The Salford Group suggested accessing GPs, Social workers, Women's groups, schools, children's services, and the police. However they perceived the major barrier to access was a lack of understanding of Asian culture. The group reported that mainstream services were usually accessed at a stage of desperateness because social workers or the police might immediately suggest radical, wide ranging solutions such as leaving home, paying a visit to the family, or even not taking them seriously, rather than providing space and support earlier to talk through difficulties and options. The groups also commented that sometimes wide-ranging solutions were actually appropriate for women in crisis situations who needed to take rapid action. The advantage, however, was described as the anonymity afforded to Asian

women who could articulate their problems in English, when talking to outsiders to the community. Racism was again considered the main barrier to service accessibility and the group proposed that mainstream services stereotype and judge Asian communities so gaining support or taking preventative action to promote well-being was generally inaccessible until crisis services had to be approached.

5.3.4.2 Improving Service Provision

The 42nd Street group initially stated that it did not matter what improvements were made to services the fundamental issue was that they could not trust anyone with their personal problems. However with further prompting and encouragement to think about the level of distress a woman might feel they suggested that it would be useful to advertise services or raise awareness about what was meant by 'psychology', 'counselling', or 'mental health', in places where the Asian community were located, for example, Asian Sound Radio. The other issue they raised was that if they were going to talk to somebody and get to know them they would want them to be easy going and of the same background. However, one woman said that if she had to she would only talk to someone outside of the community. The young women said they felt unsure of how services could be improved. This may have been because they had few experiences of accessing services.

Once again the BWG said they would not be able to trust anyone with their personal problems, not even the Bangladeshi Women's Project, not because it was a bad service, but because of fear of the community grapevine. Telephone helplines were difficult to access because of money problems. They would fear lack of understanding of their culture or religion also. They were adamant at first that they would not access services. Once again after prompting them to think about someone having serious problems and feelings of isolation and by providing an example of a counselling service with access to counsellors from places outside of Manchester, they eventually said 'Yes'- a service with a Bangladeshi woman who did not live in their local community, who came from outside Manchester - might convince them to access it. They asked the facilitator to go ahead and set this up! They also said that it would be most useful to have leaflets translated into Sylheti about services, since most people in their community were able to read this language. These were therefore all measures that would help to overcome the barriers to accessing services.

The Saheli group proposed that GPs should give out information to patients; they suggested compulsory visits to extended families, earlier intervention to provide clear support and options to Asian women experience abuse etc. However, they strongly argued that outside agencies could not understand the consequences of help-seeking for Asian women. They agreed there was lack of knowledge amongst agencies of how to support Asian women without judging them. They also proposed that groups should be run for women to get together and talk, similar to the research discussion they were having. This would indicate that the development of facilitated self help groups would be viewed favourably.

Suggestions for improving services also included: advertising them in the right places where Asian women could access them, especially if they could not read/speak English; services in schools to young Asian women; running local groups; health visitors should be trained to provide information to young mothers on services; Urdu leaflets; awareness raising on mental health, service provision and access, even with children. Women might be more likely to talk to Asian workers however they would need to ensure workers were trustworthy and would like to have some indication of their values beforehand, to overcome barriers such as fear of workers conspiring with families or emphasising conservative community values. This conspiracy is, however, not limited to Asian workers as the betrayal experienced by one of the groups from mainstream agencies (as well as the survivor accounts) demonstrated.

5.4 Summary and Conclusions

5.4.1 Summary and Indicators of Good Practice

5.4.1.1 Definitions

All the group discussions were somewhat stilted when the question of definitions was raised. Women communicated their answers about definitions of mental distress and attempted suicide and self harm in terms of social, political and economic pressures, both within and outside the community that resulted in mental distress. It was with further prompting and a few examples that women provided direct examples, some from experience, and others from the community or media.

The younger women named particular emotions or broad psychological problems, whilst others required prompts using metaphors such as 'what is the experience of your heart or head when you are under these pressures?' However, further prompting was effective because women were able to describe their psychological experience but commented that they did not often get asked about it directly. This has implications for how mental health and psychology services are targeted and delivered to Asian women. In particular, the need has been identified for providers to recognise the barriers Asian women experience before being able to express their feelings, because it may have been assumed that all Asian people somatise symptoms or do not benefit from individual psychological therapies because they do not speak about psychological experience in the same way as the white population. This group research process has identified the need to phrase clearly questions about mental health and to ensure that the way such questions are framed are really heard, before assuming they have not been answered with a direct response about psychological experience.

The overall theme to emerge was how the powerful combination of external pressures (bullying, racism, family and community pressure) and systemic issues resulted in an extreme sense of isolation.

Indicators of Good Practice

- Explicitly acknowledging the impact of systemic issues on mental distress, attempted suicide and self harm.
- Attending to the needs of Asian women experiencing social isolation.
- Using a social model of mental health to address health and well-being in a holistic way.
- Providing information and advice to address external pressures e.g. benefits, children's issues, education, employment.
- Recognising different ways in which Asian women might communicate mental distress.
- Care and persistence with the way in which mental health questions are framed and assessments made.

5.4.1.2 Factors Contributing to Experiences of Attempted Suicide and Self Harm

Once again clear systemic issues (poverty, racism and sexism) emerged as major contributing factors to women's experiences of mental distress, attempted suicide and self harm. The powerful combination of affirmation of race identity and negation of gender identity in one's own community and the mixture of both gender and race discrimination in the wider community contributed to silencing women and led to increased isolation.

The consequent impact of systemic issues was that Asian women were not seen or heard by other people, both in the Asian community and in the mainstream community, which was reinforced by an extremely efficient community grapevine. This was evident in experiences of racism involving stereotyping of Asian women and Islam, an abusive use of women to convey family izzat (honour), sexism within and outside the community, specific issues of domestic violence, consequences of leaving the community, language issues, etc. Many of the issues raised were placed in the context of marriage.

In terms of the experience of young single women, issues around child abuse, unwanted pregnancy, sexuality etc. were not mentioned by the groups. This does not necessarily mean that these are not issues young Asian women face but means that Asian women may remain silent because of the pressures they are placed under or due to fear of the community grapevine. They therefore are at risk of being further isolated and unsupported without anyone to communicate their distress to. In contrast, some women in the survivor accounts discussed childhood sexual abuse. This suggests such issues emerge in one to one supportive relationships more readily than in group situations, as is the case in the 'mainstream' for issues of child sexual abuse. This also implies that whilst service consultations with Asian women's groups are important and effective, it is also important to target women who do not access such

groups to collate a broader picture of need.

The groups also generally stated that all Asian women experienced similar problems regardless of religious background. There was some discussion about how communities that had settled in different cities developed differently depending on their environment and whether there were any other Asian families in the area or not and this may well reflect and parallel regional variations in white communities. The groups generally proposed that this was about specific families being abusive rather than whole communities.

Once again the underlying theme was the sense of isolation that Asian women who were experiencing problems felt, both within and outside the Asian community, as a consequence of how systemic issues actually shaped the direction of their lives.

Indicators of Good Practice

- Ensuring all employees have a clear understanding of how systemic issues impact on Asian women's lives.
- Ensuring all staff are aware of the impact of collusion with oppressive societal values within and outside the Asian community.
- Examining implicit assumptions of staff about Asian women's experiences or being.
- Pro-actively promoting confidentiality to Asian women service users.
- Gathering good quality information about domestic violence services targeted at Asian women.

5.4.1.3 Community Support

The overwhelming perspectives described were that women would remain silent and use their personal and psychological resources and strength to overcome rather than speak out because of the fear of consequences especially being labelled and judged, unless they had supportive family members. All the women, despite having economic freedom as stated by the Bangladeshi women's group, felt a huge sense of mistrust and fear about accessing support within the community.

Indicators of Good Practice

- Being alert to dynamics of collusion with racism and sexism, in own services as well as those contracted out.

- Being alert to dynamics of collusion with oppressive societal values when signposting women to support services.
- Effective partnership working with specialist organisations such as Asian women's refuges, committed to providing support to Asian women
- Monitoring, evaluating and reviewing interpreter provision in relation to access to health service provision for Asian women.
- Emphasising confidentiality and providing safe and secure services for Asian women to access one-to-one support.

The young women from the 42nd Street group talked of how they could not bring themselves to trust the clear confidentiality policy of 42nd Street and would not choose to talk to their group leader despite the fact that they had known her for several months. The BWG felt that they would access their project for the extremely useful services they offered but were not able to rely on it to discuss their personal or family problems. The Saheli group and the 42nd group did not feel that the groups they were associated with were part of the Asian community, despite the fact that they were Asian led. This would indicate that only 'conservative' groups are perceived as part of the community, hence organisations that are 'radical' or counter-culture are perceived as outside the community. It further indicates the need for mainstream services to remain alert to these dynamics in the design of their own services as well as those that they contract out.

5.4.1.4 Mainstream Service Provision

Overwhelmingly all the groups voiced a distinct lack of trust in mainstream services and only accessing support in crisis. All the groups reacted firmly and strongly to this theme so much so that initially it engendered feelings of hopelessness about service provision. It became apparent that these barriers might go some way towards explaining why interventions and support mechanisms for Asian women fell into place at a very late stage in their experiences of distress. This should therefore alert helping agencies to respond quickly when Asian women do contact them.

Indicators of Good Practice

- Explicitly acknowledging and addressing the impact of systemic issues on mental distress, attempted suicide and self harm.
- Taking seriously and tackling issues of racism, sexism, and other oppressions as it impacts on Asian women.

- Employing more Asian women especially those not connected to local communities who are aware of the impact of collusion with oppressive societal values.
- Ensuring **all staff** are aware of issues around collusion with oppressive societal values within and outside the Asian community.
- Being alert to the fact that Asian women may access services at crisis point and therefore require a rapid response.
- Face to face promotion of services, in a variety of languages and formats, to Asian individuals, groups and organisations.
- Explicitly and transparently addressing barriers to service provision e.g. confidentiality, fear of community grapevine etc. to provide safe services.
- Developing facilitated self help groups for Asian women.
- Pro-actively and creatively addressing confidentiality issues to build trust.
- Providing first language services to Asian women to overcome barriers to interpreter provision.

Moreover, the group research process itself was useful as an intervention. Women were asked to imagine someone in a serious crisis feeling suicidal and then to suggest what kind of services might be appropriate. Although thoughts on service providers were then forthcoming, this was counteracted once again with reference to feelings of lack of faith or trust. In an attempt to look beyond the barriers a further prompt was used, this time using metaphor to describe a sense of isolation and psychological pain and the facilitators' sense of shock that women felt completely unable to access services. It was following these prompts that women said 'well, maybe..' or 'Yes..' if they could be convinced that someone would be able to understand and really empathise with their experience. Additionally, services would explicitly need to address the barriers to accessing services such as the concerns around confidentiality, the community grapevine, i.e. clear assurances of confidential services and ultimately women would not use services unless they were promoted to them directly, preferably face to face, so they could test them for themselves. One suggestion to address this need was to perhaps have in place some 'history' or 'biography' of professional experience and value systems of workers - in much the same way that this need was identified at the beginning of this research. This would mean usually recruiting women who would not respond in a racist manner and could empathise with their experience, so Asian women who lived outside of the local community. This would indicate the need for services to attend to the specificities of the experiences of South Asian women, rather than a 'blanket' or universalised provision of services.

5.4.2 Conclusion

The aim of ascertaining community perspectives was to encourage Asian women to share their perceptions of experiences of mental distress, and attempted suicide and self harm and

to comment on barriers preventing access to service provision. The information produced has facilitated the identification of a number of indicators of good practice in relation to Asian women and service provision.

The main themes to emerge during the process was an extreme sense of social isolation felt by Asian women compounded by systemic issues (poverty, racism, sexism), external pressures, and lack of appropriate or safe service provision.

The Community Perspectives aspect of the research examined particular experiences of the Asian community in relation to mental health problems as opposed to mental well-being. It might be argued that if the research approached the question from a well-being perspective then some of these issues may not have emerged so clearly. Alternatively, the more positive aspects of the context of Asian women's lives may have emerged. Additionally, targeting a group to discuss problems within and outside particular communities might also lead to further labelling and stereotyping of those communities.

The information produced in this report must be taken together with information about what is happening in other communities, especially white communities, where mainstream groups of people are also over-represented in certain categories (e.g. young men and suicide), and not used to particularly focus on problematising Asian communities.

6 CONCLUSIONS AND RECOMMENDATIONS

This study was set in the overall national policy context of reducing suicide and undetermined injury by at least a further sixth by 2010 (Our Healthier Nation) as well as the National Service Framework for Mental Health, which makes the prevention of suicide one of its key priorities. At a more local level, within Manchester, Salford and Trafford (MST) HAZ's mental health action plan, the target is to reduce suicide by 5% for South Asian women by 2002.

Measuring rates of suicide is complex, but the current measurement is that there are just over 4,000 deaths from suicide a year nationally (Kelly and Bunting 1998, Chief Medical Officer, 1998). Whereas national figures break down the number of suicides by age and gender, they do not identify ethnicity. However, the research carried out by Soni Raleigh (1996) indicates that suicide is high in young Asian women compared to other ethnic groups. Studies by Merrill et al (1986, 1990) indicate that risks are high in UK born Asian women. As Soni Raleigh also notes, the high rates of suicide and attempted suicide is consistent in the international literature (e.g. Flisher and Parry 1994). All the available information, including qualitative studies such as this, strongly indicate the need for the provision of sensitive and relevant services to South Asian women attempting suicide and/or self-harm.

The importance of wider contextual issues, particularly racism and sexism are especially relevant for this study as well as how these intersect with mental health policy and practice. Evidence from a number of sources illustrates unequal access to and treatment of Black people within the mental health system (e.g. Ahmad, 1992; Fernando, 1991; Littlewood & Lipsedge, 1982). However, the specific experiences of Black women are largely excluded, both in the literature on 'race' and mental health and women and mental health (Aitken 1996; Burman et al, 1998). Hence the needs of black women remain hidden. Clearly, mental health policy and practice at a local level (MST HAZ) is part of this wider context.

Whereas this study helps to make visible previously invisible experiences and to engage with the specificity of South Asian women's experiences of distress and their experiences of helping agencies, it is crucial that this does not lead to the further pathologising of South Asian women and communities. In terms of the specific concerns of this report, it is important that the problem is not seen to reside in, or with, South Asian people or communities, but in the contexts and services whose responsibility it is to support them. Hence key to our study has been our concern that this research does not itself perpetuate stereotypical constructions of South Asian women as passive victims, or of assumptions of South Asian communities as homogeneous along lines of gender, class or culture.

The conclusions of this report are based on the analysis of individual interviews and group discussions with: 8 senior managers, 18 worker discussions, 7 survivors of attempted suicide

and self-harm and 4 South Asian women's groups. The following key issues emerged as crucial:

6.1 Invisibility of South Asian Women in Service Responses

The invisibility of South Asian women's attempted suicide and self-harm in service responses is striking. Given what evidence is available at a national level, and in qualitative studies (e.g. Yazdani, 1998) and this study, it is clear that urgent action needs to be taken to improve and develop service responses to South Asian women in relation to attempted suicide and self-harm. The first stage is therefore to recognise that there is a need to provide accessible and sensitive services to this population. Central to this, is the role of senior managers, both commissioners and providers. Local Implementation Teams also have a crucial role to play. A strong sense of ownership of the issues together with the necessary political will is required at the core of mental health commissioning and provision within the MST HAZ area, and decisive action taken by those with the responsibility and authority to act (**Recommendation 1**). It is also our view that a small South Asian population in certain areas should not imply a lesser institutional commitment to providing appropriate and relevant services.

6.2 Current Configurations of Mental Health Services

Currently the majority of mental health services in relation to South Asian women (and probably other Black women) are characterised by three main approaches: universalism, the privileging of 'race' over gender, and 'matching'.

6.2.1 'Universal' provision

The evidence clearly illustrates that universal or existing generic provision has not taken into consideration the needs of South Asian women. Most senior managers interviewed, appeared to be reluctant to focus specifically on South Asian women, either because of the small percentage of South Asian people in certain localities or because it was felt that mental health services needed improving for everyone – not just South Asian women. However, the universalist framework operates from a 'colour blind' perspective and the exclusion of South Asian women in the consideration of mental health services as evidenced in this report, and the need to justify spending resources on this group, requires challenging. Central to this, is the need for a re-conceptualising of the issues with an understanding of the intersections between 'race', gender, and class (**Recommendation 1**). This new frame of reference could provide opportunities to adopt a more radical approach by starting with the needs of South Asian women, with ripple effects into improving services for other women too (e.g. single sex accommodation, audio/visual information about services, choice of male/female worker, home-based or centre-based services and appropriate child support).

6.2.2 Privileging 'Race' over Gender

The privileging of 'race' over gender was widespread both in management thinking, planning and actions, and in the working practices of many of the organisations interviewed, both white and South Asian. The serious consequences for South Asian women from this approach do not appear to be recognised, illustrating a major gap in the understandings of commissioners, providers and workers providing services (**Recommendations 1 and 2**). The exceptions to this was in agencies that operated both gender sensitive and anti-racist services.

'Race' anxiety, fears around 'political correctness' and the reluctance to challenge what are assumed to be cultural practices, all reify culture, and hence unequal power relations based on gender can be seen as acceptable (i.e. as part of the culture) within South Asian communities. The stereotype of the submissive and docile South Asian woman combined with the view that the oppression of women in South Asian communities is acceptable can lead to risky assessments which not only fail to protect South Asian women, but serve to perpetuate systems of oppression based on both racism and sexism as illustrated in the survivors' accounts. The privileging of 'race' over gender was also evident in partnership arrangements and in the contracting of services. The focus on partnership and contracting arrangements tended to rest primarily on an understanding of diversity based on cultural groupings (e.g. the Pakistani community, the Bangladeshi community etc) in a way which overlooked inequalities based on gender and other oppressions within these communities. Plainly, it is not being suggested here that gender should privilege issues of 'race', but rather that the dynamics of the two are recognised and worked with. This is not to deny the importance of cultural understandings, but to emphasise the importance of, and an alertness to issues of power and oppression both within and outside of South Asian communities. It is therefore concluded that the current privileging of 'race' over gender and the consequences of so doing need to be fully understood, and that new and more differentiated forms of commissioning, provision and partnership working need to be in place which are able to engage with multiple and interconnecting sites of oppression (**Recommendation 1, 2 and 4**).

6.2.3 'Matching'

A further response to the call for culturally sensitive services has been to 'match' service users with practitioners from the same ethnic/cultural background or to contract services from South Asian organisations. Given the plethora of variables between any two people, matching is a difficult concept to put into practice. Questions such as which variables are to be matched, what gets included and what is omitted and whose choice this is, are often overlooked. Within this, it is acknowledged that some workers may refer on because they genuinely believe that South Asian organisations (or workers) will be better equipped to meet the needs of South Asian women, and that workers who are not of a South Asian background may feel de-skilled in working with this group. However, both the survivor accounts and community perspectives point to the need for choice to be available in service

provision in terms of gender, 'race', culture, geographic location and so on. Therefore, it is urgent that white workers develop their understandings, knowledge and skills to enable them to work inter-culturally (**Recommendation 2**). It is equally urgent that workers in South Asian organisations are helped to develop the competencies required to work in this field, and that all workers (including link workers and interpreters) are provided with adequate support and clinical supervision, given the strong emotions evoked both in terms of suicide and self-harm and on issues of 'race' and gender. (**Recommendation 2 and 3**).

In relation to South Asian groups offering services in mental health, it is vital that managers and workers (including commissioners and providers) are aware of the differences in the value base or politics of the South Asian organisations they refer on to, or purchase services from, as these differences have serious consequences for the appropriateness of services to South Asian women. Clearly, partnership or contracting arrangements with patriarchal or 'conservative' South Asian organisations will be unlikely to respond to the needs of South Asian women with issues of attempted suicide and self-harm as many of the contributory factors to distress challenge notions of traditional family values (**Recommendation 4**).

However, some very positive, powerful and supportive South Asian services and interventions were identified. They are being made by gender-specific organisations who are also operating from an anti-racist stance and are able to 'hold' and take appropriate risks around the complex work of attempted suicide and self-harm as it relates to South Asian women. It is therefore concluded that such organisations should be strengthened and further supported (**Recommendation 4 and 5**) whilst at the same time ensuring that mainstream organisations are also able to respond appropriately (**Recommendations 1 and 2**).

6.3 Circularity of Referral Process

An important finding to emerge from this study is the gaps in service provision created by a circular referral process. Statutory agencies refer South Asian women service users to some South Asian organisations who do not feel equipped to deal with issues of suicide and self-harm and thus refer them back to the statutory sector. Hence the needs of vulnerable South Asian women are clearly not being met by this process – either by the statutory sector or by (some) South Asian voluntary sector groups. Recommendations 1 – 4 respond to these gaps, by highlighting the need for both mainstream and South Asian organisations to develop their capacities to work in this complex field.

6.4 Partnership and Contracting Arrangements

Three key areas are summarised here: the impact of the contract culture, inclusions and omissions in current partnership arrangements and the dangers of tokenism.

6.4.1 Impact of the Contract Culture on the Voluntary Sector

The evidence presented strongly suggests that the implications of the contract culture are that firstly, there is a sense of competition rather than collaboration between voluntary sector organisations which prevents the sharing of good practice, pooling of resources, training and joint development of new initiatives. In this way, opportunities for joint working and learning are lost. This is especially problematic when working with 'niche markets' both in terms of suicide and self-harm and South Asian women. Clearly a joint approach would have much to offer, both in terms of a 'best value' agenda and a best practice perspective. One conclusion that could be drawn is that commissioners need to act to develop and resource a collaborative framework that is woman-centred, anti-racist and working in partnership with survivors to counter the culture of competition that has emerged. (**Recommendation 6**).

Secondly, the preference given to outcomes rather than process in monitoring and evaluation procedures is problematic, especially in the area of attempted suicide and self-harm as adequate time, successful relationship building and engagement with systemic issues (e.g. housing, immigration etc) with such service users is key to the prevention of suicide. It needs to be acknowledged that this is time consuming, emotionally demanding and skilled work which does not necessarily lend itself easily to being 'measured'. Furthermore, funders' monitoring requirements frequently take up valuable time and resources, diverting resources from service users to funders' priorities. It is therefore important that commissioners make appropriate provision for this in their funding and support arrangements with voluntary sector organisations (**Recommendation 7**).

Thirdly, the traditional strengths of the voluntary sector, particularly campaigning work and radical practice, which we consider to be essential for working with issues of suicide and self-harm, is also jeopardised with tightly specified contracts by replicating funders' priorities both in terms of concentrating on the 'medicalisation' of service users and the consequent emphasis on service delivery. The independent campaigning and development work of the voluntary sector highlights creative and responsive practice which needs to be supported. It is therefore vital that space is created for voluntary organisations to campaign and to develop innovative and radical ways of working in this complex area of work (**Recommendation 7**).

6.4.2 Current Inclusions and Omissions in Partnerships

The whiteness and maleness of many service user and carer groups was evident with very few structures for encouraging the involvement of South Asian service users or carers. Attention was also drawn in the analysis to the ways in which service user, carer or community consultations can be tokenistic, marginalised and experiences exploited or ignored within decision making processes. Issues of representation are difficult and perhaps a move towards participation may be less exploitative with appropriate acknowledgement (including payment) of the contributions being made either by individuals or organisations (e.g. Martins, 2001).

The analysis also stressed the importance of listening and acting upon the many and frequently contradictory voices within communities which necessitates an alertness to the dynamics of power and oppression based on inequalities, for example, gender, both within and outside of communities. Significantly, the perspectives of South Asian women who have attempted suicide or who self-harm are largely absent from existing mechanisms and it is crucial that these voices are included. Given the links (as discussed below) between domestic violence and attempted suicide and self-harm in this study and elsewhere, a practical way forward would be to include women's refuges in mental health partnerships and to further develop this sector in an empowering and constructive way (**Recommendation 4, 5 and 6**). Clearly, highlighting refuges should not now result in additional tasks being expected of what is already an under-resourced sector. It is crucial that any developments in involving refuges as partners do not replicate and reproduce current patterns of tokenism. It further needs to be acknowledged that any such development will clearly require resourcing.

6.4.3 The Dangers of Tokenism: Mainstream and South Asian Services

Although specialist South Asian mental health projects are to be encouraged and need to be strengthened, in the context of suicide and self-harm it is vital that they are woman-centred and anti-racist, and that the workers have the required competencies to work effectively with issues of suicide and self-harm. The relationship between such services and funders based on the evidence in this study, indicates that they are a largely tokenistic response, with unrealistic and high expectations of South Asian services. Whilst on the whole senior managers recognise that their own services need to be more sensitive and relevant, little evidence was offered as to how this was to happen. In relation to suicide and self-harm, the picture emerging from workers from South Asian mental health projects is they would refer back to mainstream services and co-work where feasible. Similarly, the funding of generic South Asian community groups whilst providing "low intensity" support do not offer support in times of crises and again women in distress would be referred back to mainstream agencies. Hence the circularity of this process cannot be ignored and it is essential that mainstream services act to ensure that their services are more accessible (**Recommendation 1, 2 and 4**).

6.5 Factors contributing to South Asian women's attempted suicide and self-harming

Central to the planning, management and delivery of services needs to be an understanding of the factors contributing to South Asian women's attempted suicide and self-harm. Many senior managers as well as workers (white and black) talked about the problems of living in two cultures and the difficulties encountered in negotiating the differences. They saw this to be a key factor in South Asian women self-harming and attempting suicide. Significantly, this was not mentioned by any of the survivors and was discussed in only one of the women's group discussions.

The 'culture clash' analysis has several drawbacks. First, cultures are seen as essentialised, fixed and rigid rather than as dynamic and evolving. Second, implicit within this is the notion that it is only 'Asian' culture that is affected by the difference, so that examples of the way in which aspects of Asian culture impact on the rest of society are overlooked and minimised. Third, the focus on 'cultural' issues help to camouflage and sanitise the brutality of women's lived experiences and furthermore, in this context culture – or rather 'Asian culture' could be represented as deficient and problematic. Fourth, and probably most important, what the 'culture clash' analysis does is to de-contextualise and to mask, ignore and perpetuate unequal power relations and to intervene in ways which make services inaccessible and insensitive to those whom they may be trying to reach. More specifically, this approach fails to engage with or to acknowledge issues such as sexual abuse, domestic violence, racism, immigration, patriarchy, forced marriages, and poverty. These are systemic and structural, and are very clearly articulated in the survivors' accounts of what led them to attempt suicide and to self-harm. It is therefore crucial that cultural understandings are located within the wider and intersecting contexts of racism, sexism, and class. **(Recommendation 1, 2 and 3).**

Within this study, a range of inter linking factors, mainly systemic, were mentioned by South Asian women as contributing to their suicide attempts and self-harming. These were: sexual and physical abuse, domestic violence, immigration issues, forced marriages, racism, and issues of loss. Issues that were closely allied and generated a lot of stress included poverty and homelessness. Similarly, many of these factors were also identified by the women in the community perspectives part of this study as leading to suicide attempts or self-harm. Sexual abuse, physical abuse, domestic violence are also cited in studies with white women as contributory factors to attempted suicide (Liebling 1997, Spandler 1996). In comparing the experiences of distress of white women and South Asian women, it needs to be understood that even where factors are in common with white women (e.g. domestic violence, sexual abuse), access to services for Asian women is far more difficult. Coupled with racism, isolation is much more acute with correspondingly fewer options to turn to. As the community perspectives strand of the research illustrates, mental health agencies will need to be much more proactive in winning the trust of South Asian women. This finding corresponds to other studies (Commander et al 1997, Rawaf and Bahl 1998) which also demonstrate that the stigma associated with mental distress can be exacerbated by racism in the assessment, care and treatment offered to Black people.

The age range of survivors interviewed in this study, was from 17 years to 30 years. The most common method used for suicide attempts was through overdosing although other methods were also used: hanging and slashing of wrists. Those who self-harmed cut themselves, used burning, drank substances such as bleach or head lice shampoo, or misused substances including food, alcohol and illegal drugs. Significantly, three of the survivors either attempted suicide or started self-harming in their early teens and five of the survivors had attempted suicide more than once. The age at which self-harm or attempts at suicide began, strongly indicates the need for youth services and especially schools, (see also NAWP, 1998) to be alert to

issues of self-harm and attempted suicide in young South Asian women, whilst at the same time guarding against the pathologisation of South Asian communities (**Recommendations 1, 2 and 8**).

6.5.1 Domestic Violence and Attempted suicide/self-harm

A key theme clearly emerging from the survivor accounts are the links between domestic violence and attempted suicide and self-harm, as all but one of the survivors interviewed had experienced domestic violence. Whereas the generalities of domestic violence and commonalities with white women's experiences are important, the specificities of South Asian women's experiences of domestic violence also need to be attended to. Hence considerations and understandings of domestic violence and distress also need to be located within the context of housing policy, racial harassment, immigration, service responses as well as cultural concepts such as honour and shame as discussed fully in the survivors accounts and in the community perspectives.

Attention was drawn to the ways in which state racism and patriarchy, through immigration, gives rise to the potential for the exploitation and abuse of women as evidenced particularly in one of the survivor accounts in relation to the "one year rule." As illustrated, the state can be seen to be an active partner in the violence against women. Despite recent concessions to the one year rule, it is unlikely that this will make any material difference to South Asian women in this situation. The evidence also illustrated how the key principle in welfare policies of the 'safety net' does not apply to this group as they have no recourse to public funds. It is clear that South Asian (and other) women who are subject to the one year rule, and who are in abusive relationships, are extremely vulnerable and urgent action needs to be taken to support them. Moreover, issues of housing and money are not restricted solely to this group, as speed of response in housing is especially crucial to the safety of South Asian women fleeing abusive environments, both to deal with racial harassment in "white" areas and the need to maintain anonymity from South Asian communities. (**Recommendations 4 – 7 and 10**). As is also illustrated in various studies (e.g. Davies and Betteridge, 1997, Shepherd et al, 1994 Slade et al, 1995), mental health service users themselves argue that proper housing and an adequate income are some of the most important aspects to care.

6.6 Survivors' Experiences of Services

Survivors had come into contact with a wide range of agencies including: social services, education, police, housing and benefits agencies, primary and secondary level health care, specialist South Asian mental health services and women's refuges. Survivors' experiences of these agencies point not only to a failure of a wide range of services in meeting the needs of South Asian women, but also how services often (unwittingly?) put them at further risk. The evidence also indicates that South Asian women's first contact with services is when they

are in crises, rather than at earlier, less acute points. This would suggest that primary care services need to be better targeted and more sensitive to the needs of South Asian women.

The main service sector that was viewed positively by survivors were women's refuges (by those who had used them). Other services such as a specialist South Asian mental health project were also mentioned positively, as were some statutory sector services. On the basis of the overall evidence in this report, it is concluded that service interventions which engage both with the practical (e.g. housing, benefits etc) as well as emotional support are well received by survivors. Significantly, the South Asian women's refuge also makes efforts to work with women who have no recourse to public funds because of their immigration status. This area of work needs to be further developed by all refuges with appropriate 'independent' funds, to prevent an unfair burden being placed on a single South Asian women's refuge, and to prevent tokenism and marginalisation (**Recommendations 4 - 11**).

Most survivors found their families' responses after their suicide attempts or self-harming to be very punitive and uncaring. This was mirrored for many survivors in the attitudes of mental health workers and in the failures of services as outlined above. Firstly, it is urged that risk assessments in various settings, but particularly in A&E departments, need to give due regard to the sort of 'care' women are going to receive within the family. Idealised notions of strong family values in South Asian cultures need to be tempered by an understanding that families can also be a site of oppression for women – just as white families are. Assessing for risk in this way also highlights the need for supported housing and strong links with women's refuges and other gender sensitive, anti-racist services (**Recommendations 2, 4, 5 and 10**).

Some of the survivor accounts also point to a failure of accurate assessments from professionals involved in child protection. It is important that these agencies review their procedures and further develop their practice in this area of work (see survivor accounts) (**Recommendation 12**).

Second, the strong feeling of survivors that they were not 'heard' or understood, either by their families or by mental health practitioners, alerts us to the need to attend to the business of understanding – a quality that many mental health practitioners (and their managers) may mistakenly take for granted. It is therefore not surprising that, in terms of services, what survivors think would better support them are workers who are more understanding, who have time for them and do not judge their self-harming either in terms of their behaviour, their gender or their cultural background. Hence developing these qualities in workers in a range of settings is important as is the need for more specific gender sensitive and anti-racist counselling services. Preference for first language interventions (rather than through interpreters) was also clearly articulated. The smallness of South Asian community networks also gives rise to the need to think carefully about the concerns raised by the community perspectives in relation to confidentiality. (**Recommendations 2 and 8**). Bhugra & Bahl (1999) and McKenzie et al (1995), point out that people from minority ethnic groups are much less likely than white people to be offered or referred to psychological services. However,

the interviews with survivors demonstrate that South Asian women do value the opportunity to talk about their experiences. Survivors, as well as one of the women's groups interviewed, also felt that the development of (facilitated) South Asian women's survivor groups would be of benefit and help to break isolation (**Recommendation 9**).

Third, the survivor accounts also articulate the need for working in a way which recognises and values people's strengths, that resists labelling, and that works with an understanding of distress rather than solely with the symptoms of distress (**Recommendations 1, 2 and 3**). This is in line with other literature on self-harm (e.g. Arnold 1995, Johnstone 1997, Pembroke 1994).

Above all, what is very evident in these survivor accounts, is that far from the usual construction of South Asian women as passive and accepting of oppression, women have fought and survived systems of oppression based on class, racism and sexism and have also challenged cultural norms of South Asian communities at great emotional (and often physical) risk to themselves. Furthermore, they have often achieved this despite the general lack of care and consideration shown to them by 'helping' agencies. It is therefore crucial both for the understanding of South Asian women's distress and in making services more sensitive, that wider social issues are addressed – both in the configuration of services and in the training and perspectives of workers in the field.

6.7 Recommendations

The following recommendations have been formulated on the basis of the discussions, evidence and analysis presented in the report. Whilst they have emerged from the specific considerations of South Asian women, attempted suicide and self-harm and service responses to this, clearly there are links with wider issues of 'race', gender and mental health commissioning and provision. In particular, attention is drawn to the need to challenge racism and sexism at all levels, both within Manchester, Salford and Trafford HAZ, and beyond, including legislation and national policies which disadvantage and oppress Black communities, service users and carers.

Recommendation 1

Management Development Program for Senior Managers (Commissioners and Providers)

Aim: To help senior managers develop and operationalise a HAZ wide and an individual agency perspective to gender-sensitive, anti-racist work in relation to suicide and self-harm services to South Asian women.

Such a program should address issues such as: the current invisibility of the consideration of the needs of South Asian women, the privileging of 'race' over gender in commissioning, partnership arrangements and service provision, contributory factors to South Asian women's suicide attempts and self-harm, the need to make representations at a national level to challenge legislation and policy which disadvantages South Asian women and other Black people, the need for non-medicalised services, and service specifications, evaluation and monitoring processes that are inclusive of South Asian women.

Recommendation 2

The Development and Implementation of a Staff Development Strategy (for mainstream and South Asian organisations)

Aim: To help mental health practitioners develop sound gender sensitive, anti-racist practice and to work competently with South Asian women with issues of suicide and self-harm.

Such a strategy should enable workers to understand the interconnectedness of the impact of racism, sexism and other oppressions on themselves and others, to challenge the 'colour blind' approach and dominant hierarchies within 'helping' relationships, understanding of the contributory factors of suicide and self-harm in South Asian women leading to more accurate risk assessment, care and treatment, safe guarding confidentiality, developing skills in working inter-culturally, and counselling skills.

Recommendation 3

Non-managerial Case-work Supervision and Support for Mental Health Practitioners and Link Workers (All sectors)

Aim: To ensure safe practice, provide support to practitioners to address the complexities of working not only with issues of 'race' and gender, but also attempted suicide and self-harm.

Recommendation 4

The Development and Implementation of More Inclusive Partnership Working Arrangements with South Asian Women

Aim: To rectify the current omissions in partnership arrangements, particularly of South Asian women, to recognise the consequences of partnerships with 'conservative' South Asian groups, to address issues of tokenism, to recognise and address power dynamics within partnerships and to ensure that mainstream agencies do not abdicate responsibility onto South Asian groups.

Recommendation 5**Strengthening the Role of South Asian and Other Women's Refuges, and Other Gender Specific, Anti-racist Services**

Aim: To recognise and work in non-exploitative partnership with a currently unrecognised source of support to South Asian women with suicide and self-harm issues by increasing resources in this sector to further develop innovative practice and to respond to the needs of South Asian women (and other women) subject to the 'one year rule'.

Recommendation 6**The Development of a Properly Resourced Women-only Collaborative Forum Working on Issues of Suicide/Self-harm and South Asian Women**

Aim: To counter the current culture of competition between agencies and to promote joint working and innovative practice in this area of work between agencies, senior managers, practitioners and survivors.

Recommendation 7**The Development of Core Funding Strategies for Voluntary Organisations Working with South Asian Women and Attempted Suicide and Self-harm**

Aim: To recognise and recompense for the additional requirements of commissioners in relation to monitoring and evaluation, to recognise that partnership working requires time and resources and to allocate resources specifically for the development of innovative practice and campaigning work, or to increase capacity within voluntary organisations to raise funds independently of the statutory sector.

Recommendation 8**The Development of a Black Women's Counselling and Complementary Therapy Service**

Aim: To be part of a suicide prevention service development to respond to the needs of South Asian women (and other black women) for confidential counselling in relation to feelings of attempted suicide, self-harm as well as other mental health issues by developing and drawing upon non-medicalised, gender-sensitive, anti-racist ways of working.

Recommendation 9**The Development of South Asian Women's Survivors Groups**

Aim : To develop facilitative and supportive groups to break isolation, share experiences and build on survivors' strengths.

Recommendation 10

Provision of Safe and Supported Housing for South Asian Women in Distress, Including South Asian Women Attempting Suicide

Aim: To work in partnership with other agencies providing housing with mental health support to address the need for both practical and emotional support, to provide accommodation for women who have no recourse to public funds, and to have a practical alternative to back up risk assessments where returning to the family may pose further threats to well being.

Recommendation 11

To Support Voluntary Organisations to Develop an Immigration Welfare Fund

Aim: To set up a non-stigmatising, quickly accessible source of funds, to respond to the needs of South Asian women (and others e.g. asylum seekers) who have no recourse to public funds due to their immigration status.

Recommendation 12

Effective Use of Child Protection Policies and Procedures

Aim: To address potential gaps in the implementation of child protection policies and procedures (as indicated in the survivor accounts) in relation to South Asian children and young people and to acknowledge and act upon the links between domestic violence and child protection issues.

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APPENDICES

APPENDIX 1

Service Map

Through the process of the research, it has been possible to draw up a map of *potential* sources of help for South Asian women who self-harm and/or are suicidal. This was largely through networking with workers, other researchers, organisations mentioned by the research participants, womens groups, personal contacts and local knowledge of services. It does not include statutory services except where these have dedicated services either in relation to suicide and self-harm or to specific South Asian mental health services. There are a number of other sources of useful information such as the Voluntary Action, Manchester (VAM) directory of voluntary and community groups in Manchester, Salford Council for Voluntary service directory and the Health through Action (M, S & T HAZ) directory of community development and participation workers in Manchester, Salford and Trafford.

The service map is presented in two parts. The first part is a listing of the organisations with a brief summary of their activities. This summary is based on information in publicity leaflets and through telephone contact. Some agencies were also interviewed as part of the research. The second part is a table illustrating the information thematically. In order to get a richer picture of mental health services, it is important that this list is read in conjunction with the text.

List of Organisations

Asian Women's Self-help Group

Tel: 0161 232 7312

There are two drop-in sessions for isolated Asian women. Mondays: 1 p.m. to 3 p.m, Imex Business Park, Studio 20 (2nd Floor), Hamilton Road, Longsight, Manchester M13 0PD. Tel: 0161 244 2220 and Fridays: 1 p.m. to 3 p.m. at 2, Sellborne Road, off Barlow Moor Road (next to Training Wise), Chorlton. Tel: 07773 725405.

Awaaz

Address: 464 Cheetham Hill Road, Cheetham Hill, Manchester M8 9JW.

Tel: 0161 740 3273/ 0161 721 4441

Fax: 0161 702 3032

Awaaz describes itself as an ethno-sensitive mental health project, supporting Asian people with emotional difficulties and providing culturally sensitive services. It offers an advocacy

service, employment and training opportunities as well as therapeutic massage and supported leisure.

Azeemia

Address: 106, Barlow Moor Road, West Didsbury, Manchester.

Tel: 0161 448 9149

Run meditation and relaxation workshops for mental health service providers and users based on Sufi healing. The Azeemiah Foundation runs an open evening, every Sunday from 7 p.m. to 9 p.m. at 110 Ayres Road, Old Trafford, Manchester.

Bangladeshi Women's Project

Address: 360 Dickenson Road, Longsight, Manchester M13 0WG.

Tel: 0161 257 3867

Provides mental health support to Asian women, advice on benefits, housing, immigration, mother and toddler group and other daytime activities.

Bibini Centre for Young People – Family Support Service

Address: Unit 6, St Wilfrid's Enterprise Centre, off Royce Road, Hulme, Manchester M15 5BJ

Tel: 0161 232 7977

Fax: 0161 232 7989

The Family Support Service supports young people of African, Caribbean, Asian and Black British descent. It offers advocacy, befriending, play therapy and counselling.

The Bibini Centre also run a supported housing scheme for Black young people under 20, primarily for young people leaving care (Tel: 0161 248 8485).

Black and Asian Counselling Service

Tel: 0161 226 0529.

Counselling sessions are on offer Monday – Friday 4.30 p.m. to 8.30 p.m. and Saturdays from 1.00 p.m. to 5.00 p.m. Counselling is free for unemployed people, but contributions are appreciated.

Creative Support

Address (Head office): 5th floor, Dale House, 35, Dale Street, Manchester M1 2HF.

Tel: 0161 236 0829

Fax: 0161 237 5126

Creative Support provides supported tenancies and housing options for people with mental health difficulties as well as support such as: day services, specialist services for women,

including for Black and Asian women, for survivors of abuse, for people with dual diagnosis, young people and ex-offenders. It provides services across the North west, the North east and the Midlands.

Deliberate Self-harm Team

Address: 15 Lorne Street, Manchester Royal Infirmary, Manchester M13 0EZ.

Tel: 0161 276 8865/8866

During normal office hours, patients attending with deliberate self harm are assessed by a member of the deliberate self-harm team. Patients are offered follow-up home visits usually within 24 hours of being discharged from hospital after a deliberate self-harming incident. A detailed risk assessment is carried out and the patient is offered up to 4 sessions of psychodynamic interpersonal therapy at home by a nurse therapist. If further help is required, the nurse therapist will refer on to appropriate agencies.

Forty Second Street

Address: 2nd Floor, Swan Buildings, 20 Swan Street, Manchester M4 5JW

Tel: 0161 832 0170

Fax: 0161 839 5424

Forty second street is a community mental health service for young people aged 14-25 covering Manchester, Salford and Trafford. It offers a help line, individual counselling, drop-ins and group work, including groups for black women and support for young lesbians and gay men, and has dedicated services for suicide and self-harm.

Hosla – Asian Women’s Outreach Project

Address: Kath Locke Community Health and Resource Centre, 123 Moss Lane East, Hulme, Manchester M15 5QD.

Tel: 0161 455 0227

Fax: 0161 455 0233

This project offers support, information and advice to Asian women of all ages who have experienced or are experiencing domestic violence. Links women to other relevant services. Home visits offered.

Kath Locke Centre (Community Health and Resource Centre)

Address: 123, Moss Lane East, Hulme, Manchester M15 5DD

Tel: 0161 455 0211

The Kath Locke centre houses a wide range of statutory and voluntary agencies including mental health teams, district nurses, dental practice etc. It also has a counselling and complementary therapy service.

Longsight/Moss Side Community Project – Drop-in for Asian Women

Address: The Pastoral Centre, 95A Princess Road, Manchester, M14 4TH

Tel: 0161 226 4632

As part of its activities, Longsight/Moss Side Community Project organises two mental health drop-ins for Asian women offering support, information and advice, as well as daytime activities. Drop-ins: Wednesdays, 10 a.m. – 4.00 p.m. at the Burhan Centre, 81, Beresford Road, Longsight, Manchester and Thursdays from 2.00 p.m. – 4.00 p.m. at the Cayton Centre, Cayton Street, Longsight, Manchester. Home visits are also offered.

Manchester Rape Crisis

Address: P.O. Box 336, Manchester M60 2BS.

Tel: 0161 273 4591 (Office), 0161 273 4500 (Help line), 0161 273 4514 (Black and Asian women's help line).

Manchester Rape Crisis offers a telephone help line, individual counselling or support as well as groups for women survivors of rape and sexual abuse. There is also a Black and Asian women's service, staffed by Black women.

Manchester Women's Aid 2

P.O. Box 10, Manchester M13 0RJ

Tel: 0161 248 8849.

This is a women's refuge providing safe, temporary housing for women and their children escaping domestic violence. It includes and outreach and after care project and a counselling service.

Neesa Well Women Drop-in Project

Address: Woodville Community Resource Unit, Shirley Road, Cheetham, Manchester M8 7NE.

Tel: 0161 740 2995/ 0161 795 9400

Neesa offers a range of support services to Asian women, both centre-based and home visits. Services include: Mother and toddler group, luncheon club for older Asian women, support and advice, mental health sessions, one-to-one or group work activities and support.

Pakistani Resource Centre – Trafford South Asian Mental Health Project

Addresses: Broome House, 54-56 Seymour Grove, Old Trafford, Manchester or Pakistani Resource Centre, 1 Great Marlborough Street, Manchester M1 5NJ.

Tel: 0161 912 4830 (Broome House) or 0161 237 1125.

The project offers individual and group work support and advocacy services to South Asian people with mental health issues and works in conjunction with statutory agencies, offering them 'cultural' interpretation. Also offers help and advice on benefits, housing problems and immigration.

Roby Outreach Project

Address: Dickenson Road, Longsight, Manchester M13 0NG

Tel: 0161 257 2653

Roby offers individual counselling and group work. Counselling is normally accessed via the patient's GP although some self-referrals are also accepted. A regular women's group runs on Wednesday afternoons. There are two drop-in sessions: Tuesdays and Thursdays 10 a.m. – 1 p.m.

Saheli Asian Women's Organisation

Address: P.O. Box 44, S.D.O. Manchester

Tel/Fax: 0161 945 4187

Saheli is predominantly an Asian women's refuge, but also works with other black women providing temporary emergency accommodation to women and their children experiencing domestic violence. Saheli also offers support and advice on: housing, benefits, immigration and children's issues as well as counselling support. It also has an outreach service – see Hosla.

Salford Link Project

Address: Bright Road, Eccles, Manchester M30 0WG

Tel/Fax: 0161 787 8219

An information, advice, advocacy and an interpretation and translation service for Black and minority ethnic communities in Salford. The project runs a Day Care Centre, three times a week – 2 days/week women only, 1 day/week men only. It also has a mental health support worker who offers one-to-one support.

Salford Women Working Together

Address: c/o Community Health Project, Higher Broughton Health Centre, Devendon Square, Salford M7 4TP.

Tel: 0161 708 8388.

A self-help group, predominantly Black women working towards uniting women of diverse cultures and aims to provide opportunities for women to take control of their health needs, particularly the needs of Black and ethnic minority communities. The group meets on the last Thursday of every month.

Samaritans of Manchester

Address: 72-72 Oxford Street, Manchester M1 5NH.

Tel: 0161 236 8000

Fax: 0161 236 2151

Samaritans provide a 24 hour telephone service offering emotional support for people who

feel desperate or suicidal. Also open to visitors from 9.30 a.m. to 9.30 p.m. There is also an e-mail address for people who wish to remain anonymous : samaritans@anon.twwells.com

Sojourners House

Address: P.O. Box 79, S.W.D.O. Manchester.

Tel: 0161 882 0632

Fax: 0161 860 0519

Sojourners House is predominantly a refuge for African and Caribbean women, but also works with women from other ethnic backgrounds, providing temporary accommodation to women and their children fleeing domestic violence. It also offers support and advice on housing, benefits and children's issues as well as counselling support.

South Asian Mental Health Service

Psychiatry Directorate, Rawnsley Building, Oxford Road, Manchester M13 9WL.

Tel: 0161 276 5347.

A statutory sector provision, offering one-to-one support and group work with South Asian service users. Also has link workers.

Women's Domestic Violence Helpline

Address: P.O. Box 156, Newton Street, Manchester M60 1DB.

Tel: 0161 839 8574, Minicom: 0161 834 4496.

The helpline provides a listening ear for women who are suffering or have suffered domestic violence. Advice and information on: welfare benefits, children, housing, referral to Women's Aid refuges including specialist refuges for Asian women, African-Caribbean women and disabled women. The helpline also offers the above services in; Hindi, Urdu, Punjabi and Gujarati (Mondays and Tuesdays, 10 a.m.- 1p.m., Wednesdays and Thursdays 1.00 p.m. – 4.00 p.m.).

Table of organisations: who services are offered to

AGENCY	M A N C H E S T E R	S A L F O R D	T R A F F O R D	Suicide Specific	Age Specific	Women Only	Black Women Only	Some Gender Specific Services	Some Black Specific Services	Black Only Services (Men and Women)
Asian Women's Self-help Group	✓						✓			
Awaaz	✓	✓						✓		
Azeemia	✓									✓
Bangladeshi Women's Project	✓						✓			✓
Bibini Centre for Young People	✓	✓	✓	◆	See listing above			✓		✓
Black and Asian Counselling Service	✓							✓		✓
Creative Support	✓	✓	✓					✓	✓	
Deliberate Self-harm Team	✓			✓						
Forty Second Street	✓	✓	✓	✓	14-25 years			✓	✓	
Holsa - Asian Women's Outreach Project	✓	✓	✓	◆			✓			
Kath Locke Centre (Counselling and Complementary Therapies)	✓							✓	✓	
Longsight/Moss Side Community Project - Drop-in for Asian Women	✓						✓			✓
Manchester Rape Crisis	✓	✓	✓			✓			✓	
Manchester Women's Aid 2	✓					✓				
Neesa Well Women Drop-in Project	✓									
Pakistani Resource Centre - Trafford			✓	◆				✓		✓
South Asian Mental Health Project	✓							✓		
Roby Outreach Project	✓							✓	✓	
Saheli Asian Women's Organisation	✓	✓	✓	◆			✓			
Salford Link Project		✓						✓		✓
Salford Women Working Together		✓				✓			✓	
Samaritans of Manchester	✓	✓	✓	✓						
Sojourners House	✓	✓	✓	◆						
South Asian Mental Health Service	✓			◆				✓		✓
Women's Domestic Violence Helpline	✓	✓	✓			✓			✓	

◆ Although these are not suicide specific services, these agencies were supporting women with issues of suicide and/or self-harm

APPENDIX 2**Participating Agencies**

The following agencies took part in one or more strands of the research:

Awaaz
Bangladeshi Women's Project
Bibini Centre for Young People
Central Manchester Primary Care Trust
Creative Support
Deliberate Self-harm, Manchester Royal Infirmary
Edale Unit, Manchester Royal Infirmary
Forty Second Street
Higher Broughton Health Centre
Holsa – Asian Women's Outreach Project
Longsight/MossSide Community Project
Manchester Mental Health Partnership
Manchester Metropolitan University – Student Counselling Service
Manchester Social Services department
Neesa
North Manchester Hospital (A&E)
North Trafford Community Mental Health
Trafford General Hospital
Trafford Local Implementation team
Trafford South Asian Mental Health Project
Saheli
Salford Mental Health Services
Salford Social Service Department
Sojourners
South Asian Mental Health Service (MRI)
Surrey Lodge Health Centre
Women Working Together – Salford Community Health Project

In addition, several other agencies were contacted who were unable to participate.

APPENDIX 3**Senior Managers Interview Schedule****SENIOR MANAGER INTERVIEWS****1. POLICY ISSUES (KC)**

1. Which groups are at the highest risk of suicide?
2. How does the service prioritise these groups in terms of providing a service?
3. How do you propose to implement the national service framework standard to do with the prevention of suicide in relation to S. Asian women?
4. If you have an Equal Opportunities policy, can you tell us how it is implemented in relation to suicide/self harm and S. Asian women?
5. What impact do you feel the Human Rights Acts will have on mental health services?
6. Do you conduct any ethnic monitoring of a) staff b) service users?
7. If yes, what is the information used for?
8. If no, why not?

2. SERVICE DELIVERY & COMMISSIONING (EB)

9. What factors contribute to S. Asian women self-harming or attempting suicide?
10. Do you think that the services you commission or are responsible for provide the same quality of service to white women and S. Asian women?

YES

NO

DON'T KNOW

3. WORKING IN PARTNERSHIP (KC)

Acknowledge that this section is focussing on working with service users, carers and S. Asian organisations.

15. How do you involve S. Asian carers and service users in partnership arrangements?
16. How do you involve S. Asian organisations in the planning and development of services?
17. How do you ensure that those groups actually represent all sections of the community?

4. STAFF & MANAGEMENT DEVELOPMENT (EB)

18. Who do you see as having responsibility to ensure that S. Asian women who are self harming receive a sensitive and appropriate service?
19. Can you tell us of any management actions you have taken (or are proposing to take) to improve services to S. Asian women at risk of suicide/self harm?

If no, what might help?

20. What support do you feel you might (personally) need to advance this area of work?
21. What support might others need to advance this area of work?
22. Do you see management development as having a role in this area of work?

YES

NO

If yes, what kind of skills, understandings and knowledge would be helpful?

23. Is there anything else that would be helpful in promoting this area of work?

APPENDIX 4**Interview Schedule for Worker Discussions****Workers Discussion Groups**

Name of organisation:

Workers perceptions of suicide and self-harm in relation to S. Asian Women

1. What do you understand by the terms self harm and attempted suicide?
2. What factors do you think contribute to S. Asian women self-harming or attempting suicide?
3. In what ways do you think these may be different to the experiences of white women who self-harm/attempt suicide?
4. In what ways are they similar?
5. What are your perceptions of service users who self-harm/attempt suicide?
6. What feelings does it raise for you when working with S. Asian women who self-harm/are suicidal?

Current Service Provision

7. Have you ever provided a service to this group of service users?

YES

NO

8. How would a S. Asian woman who is suicidal or self-harming access your services?
9. What kind of services do you think S. Asian women who are self-harming/and or are suicidal need?
10. What services do you provide for S. Asian women who self-harm/attempt suicide?

Examples of good practice

11. Do you feel that the service you provide is sensitive to the needs of S. Asian women who self-harm and/or are suicidal?

YES

NO

If yes, can you identify examples of good practice in relation to S. Asian women?

If no, please give reasons

Gaps in services

12. What gaps (if any) do you see in your services to S. Asian women?
In what ways could your organisation improve accessibility to S. Asian women?

Referring On

13. Where else would you refer a S. Asian woman to who self-harmed or was suicidal if she approached you for help?
14. What problems have you encountered when referring on?
15. What successes have you had when referring on?

National policy developments

16. What impact (if any) have recent national policy developments had on your everyday work?

Working in Partnership

17. Can you tell us about your experiences of working in partnership with other agencies in relation to suicide and self-harm issues with S. Asian women?
18. Which agencies (statutory and non-statutory) do you have good working relationships with?
19. With which agencies do you feel partnership relationships need to be improved?
20. What facilitates good partnership relationships between agencies?
21. What are the barriers to working in partnership with others?
22. How do you think your organisation is perceived by other agencies in the mental health field?

Bureaucracy and Defensive Practice

23. In what ways (if any) do the systems and structures around this area of work enable you to work effectively with S. Asian women who self-harm/are suicidal?
24. And in what ways do they hinder effective working?
25. What impact does the bureaucracy have on working with the risks associated with attempted suicide and self harm?

-
26. What would happen if a service user you were working with committed suicide or whose self harming was fatal?

Support for workers

27. What are the main problems you experience when doing this work?

Supervision

28. Can you tell us about the supervision you are offered?
29. In what ways is it helpful/supportive to you in this area of work?
30. What might make it more supportive?
31. How are the feelings generated by this area of work handled?

Other support

32. What other kinds of support do you get to help with this work?

Training/Staff development

33. Do you see staff training and development as having a role in advancing work with S. Asian women who self-harm and/or are suicidal?

YES

NO

If yes, what skills, knowledge and understandings do you feel you need?

Anything else

34. Are there any other kinds of support that would be of help to you in working more effectively with S. Asian women who are suicidal/self-harming?

APPENDIX 5**Interview Schedule for Survivors**

Issues explored with women survivors:

A. Womens stories

1. Background information: age, class and cultural grouping (self-identified)
2. How did you come to realise that things weren't quite right?
3. History of attempted suicide/self harm, including description of methods used
4. Exploration of reasons leading to behaviour
5. Own perceptions of the role of attempted suicide/self harm (+ves and -ves)
6. Others perceptions of behaviour – family/friends/community/helping agencies
7. Exploration of own coping mechanisms
8. Current situation

B. Help/Support/Treatment

9. Where, if anywhere did you go for help? (formal/informal)
10. What kind of support (or treatment), if any was offered?
 - Talking to a friend/member of the family/community
 - Counselling/psychotherapy/CBT
 - Medication
 - Social work interventions
 - Massage, aromatherapy, reflexology etc
 - Being part of a community group/religious group
 - Self-help group
 - Other
11. What was helpful about it?
12. What was unhelpful about it?
13. What else would have helped at the time?
14. Based on your experience, what would be the main ingredients of a high quality support service?
 - (prompts: choice of provision, location, types of workers – gender, 'race', sameness/difference etc)

APPENDIX 6**Group Discussion Schedule – Community Perspectives****Semi Structured Focus Group Interviews****Theme 1: Understanding of mental distress**

- a) What do you understand by the term mental distress?
- b) What do you understand by the terms suicide and self harm?
- c) What kind of specific behaviours do women show when they self harm/attempt suicide?

Theme 2: Causal Factors

- a) What causes South Asian women to self harm or leads to suicide?
- b) How do you think Asian women's experience might be different from other women's? (including possible differences between Indian/Bangladeshi/Pakistani communities)

Theme 3: Community Support

- a) How might an Asian woman experiencing mental health problems in general and suicide/self harm issues in particular be supported within Asian communities?
- b) What might the barriers be to effective support within the community?

Theme 4: Service provision

- a) If you knew somebody who was experiencing mental health problems and/or suicidal thoughts/self harm where would you suggest they went for help?
- b) What are the advantages and disadvantages of approaching outsiders?
- c) What is your impression of services for mental health?
- d) How might they need to improve in order to provide a good service to South Asian communities?

