Assessment of the need of BME and White Other women for sexual violence services in Northumberland

Carried out by:

April 2014
Acknowledgements

There are a series of individuals and organisations that we would like to thank for their role in this research. Firstly, we would like to thank the women that took part in Focus Group Interviews who gave up their time and spoke freely about what was a difficult subject for some. Secondly, we would like to thank those that facilitated our access of these groups, in particular Karen Kirkbride, Eileen Cartie and Adeline Balint. We would also like to thank the academics that we consulted including Khatidja Chantler and Catherine Donovan who gave us invaluable input. Thank you also to Paul Race and Michelle Sheridan from Northumbria Police and Sue Smith from South Tees Sexual Assault Referral Centre who provided us with data. Thanks to Dr. Beata Kohlbeck from Mohr Language School who helped us with accessing questionnaire respondents. Thanks also for a number of other individuals for the advice and input, especially Cath Hale from Women’s Health Advice Centre, Angela Oxberry from Women’s Health in South Tyneside and Rob Strettle from Northumberland County Council. Thank you to Sarah Pelham, currently studying gender studies at University of Utrecht, who conducted the literature review. Finally, thanks should also be offered to RCTN, who recognised a need to investigate the issue of BME engagement to address under representation and to ensure a truly equal service.

About Grace

Grace Northumberland Rape Crisis (Grace) was established in 2009 by Rape Crisis Tyneside and Northumberland, in response to a gap in specialist support for women survivors of sexual violence in Northumberland. Grace is a feminist service run by women for women which: provides a range of services to support women who have experienced sexual violence at any time in their lives; raises awareness of sexual violence affecting women; and actively challenges the values, beliefs and behaviour which contribute to the perpetration of sexual violence against women. Grace offers counselling, a helpline service, awareness raising sessions and training for professionals. Grace employs a qualified female counsellor who operates from five outreach bases across Northumberland. They also offer a telephone helpline which operates on a Tuesday, Wednesday and Thursday evening from 6.00pm to 8.30pm.

More information: www.gracenrc.org.uk

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More information: www.barefootresearch.org.uk
Executive summary

Rape Crisis Tyneside and Northumberland (RCTN), known as Grace in Northumberland, wished to understand the sexual violence needs of women who were not White British in Northumberland. The reason for this came from Grace having been in Northumberland since 2009 but having had no Black, Minority and Ethnic (BME) or White Other clients. In December 2013, they commissioned this piece of research to look into how the organisation increased the participation of non-White British Women in their services.

Prevalence of sexual violence

When national prevalence rates are applied to Northumberland, we see that on average each year and in theory, 66 BME and White Other women experience sexual violence. However, since 2010/11, Northumbria Police has only received two reports from BME women of sexual violence. It would appear that sexual violence is not being reported. If we look at RCTN’s caseload in other areas (on Tyneside), we see that it does deliver services to non White British women and this has varied between six and seven percent of their total caseload. So we know that that non White British women do access their services.

Ethnic composition of women in Northumberland

In 2011, there were a total of 2661 women aged between 16 and 59 and 4083 females (all ages) in Northumberland from BME and White Other groups.

There are two main locations in Northumberland where there is contact between ethnic groups other than White British and services:
Berwick and Blyth. These are groups of predominantly European (dominated by Polish) women (in Blyth it is a women only group, in Berwick it is a mixed gender group, although with higher numbers of women) who are supported by voluntary sector organisations.

Conclusion

There are a number of key findings which arise out of this needs assessment:

- There are small but significant non White British populations across Northumberland, with concentrations in the west, south east and north of the county. The most populous ethnic groups are South Asian and Polish.

- Reporting of sexual violence amongst BME groups is very low and confidence to report incidents also appears to be very low. There are subsequent low numbers of BME women who attend sexual assault referral services.

- Despite these low numbers in real terms, national prevalence percentages indicate that there are non White British people in Northumberland who are victims of sexual violence. Also, using regional percentages of the numbers of survivors who received or were referred to counselling services, we see that there are non White British survivors who may require counselling. In other words, although hidden, there are non White British who may require an intervention from RCTN.

- There was consensus on common elements for a service suitable and targeted for non White British women and these elements included:
  - A one-to-one service.
  - Delivered by a worker who was of the same ethnic background of clients and who spoke the same language.
  - Delivered from a local community-based centre which was already used by non White British women and during school times, i.e. after
9:30am and before 2:30pm in term times.

- Advertised in both community venues and on the Internet in a variety of different languages.

- Relationships and trust are key to disclosing incidents of sexual violence amongst non White British women.

Outside of these conclusions, we feel it is important to note a general low awareness of issues relating to violence towards women in Northumberland. We attempted to engage with different representatives from the Health Authority on this issue with little success. Also in discussions with local community-based workers, we found a general low service awareness of issues relating to sexual violence and local populations, both BME and non-BME populations. It would appear that this issue around service awareness needs to be tackled on a strategic level within Northumberland. This would best be achieved through the appointment of a strategic lead for violence against women and girls.

**Recommendations**

Based on these findings from the previous section, we make a series of recommendations for RCTN. These are:

- A programme of regular visits should be started at the BME meeting points in Northumberland and should take place on at least a six monthly basis. The objective of this activity would be to develop relationships with BME leaders and gatekeepers. To illustrate this recommendation, we refer back to the focus groups where although some women said that they would look on the Internet or look at other advertising points in the community, the majority of respondents said their preferred method would be to tell a trusted community worker, who could then access services for them. Thus, the key task of RCTN is to develop relationships and gain the confidence of those BME leaders and gatekeepers, as these where the BME referrals will come from.
Similarly, a parallel programme of visits should take place across community-based agencies, to raise awareness of the issue of low reporting and a therapeutic need amongst BME communities. This is based on RCTN figures from outside of Northumberland, which show referrals of non White British women being made by such services, including health (particular mental health) services and voluntary sector organisations.

RCTN has already invested considerable resources in translating advertising and publicity materials. However, in view of the findings of this needs assessment, the translation of advertising and promotional materials should be re-examined and re-drafted to include information about the universality of RCTN’s services and to emphasise the fact that survivors do not need to report to their Police to be able to receive their service. During the research, there was an appreciation that some non White British women felt that services in the community were only for residents and not for them. It was also thought by some respondents that services were only available if a report had been made to the Police. Such information and directions to the service must be made available on the Internet as well as in the community venues identified in this research.

A BME focused project/initiative can be constructed using the information in this needs assessment. It would seem sensible, because of low numbers (in proportional terms, i.e. because of an absolute lower number of non White British populations, there would be a lower number in real terms of prospective clients) to share such a service across the entire RCTN geographical area. This service would employ a South Asian and an Eastern European female worker (either full or part-time) to deliver services.

There are several issues which arise from the guidance literature around BME involvement, some of which having already been started, such as a
translation of advertising materials and involving volunteers from BME communities and others which are recommended from this assessment, such as the placement of publicity materials in faith venues. A key point from the literature is the need for involvement of BME representatives on their strategic governance arrangements. We would advise adding a non White British woman on the Northumberland Advisory Group and the RCTN Board. It is good practice to have a range of ethnicities within strategic management to ensure representation at the heart of the organisation. There are other recommendations that arise from the literature, although many of these relate to resources and capacity, such as: developing service user groups; and developing group based support.

- RCTN already carries out awareness raising and training work in Northumberland about sexual violence. However, we recommend that targeted awareness raising work and training needs to take place across Northumberland to raise the profile of sexual violence within BME/non White British communities. This is a wider piece of work, which implicates local strategic authorities (health, community safety and local authority) but must go hand in hand with any initiative that attempts to increase the numbers of such clients in services. Grace is in a good position to lead this, either as a specific piece of work or by embedding the subject in existing awareness and training activities.

Finally, we would like to end with a recognition that the organisation has a proven track record of engaging with BME populations in Newcastle. However, in Northumberland, there must also be a recognition that engaging with and delivering services to non White British survivors will be a long and slow process, given the current low reporting, low service awareness of the issue of sexual violence and limited meeting points of such populations. Thus, if any targeted initiative is started, it needs to be given good time to become established and achieve results.
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1.0 Introduction

Rape Crisis Tyneside and Northumberland (RCTN), known as Grace in Northumberland, wished to understand the sexual violence needs of women who were not White British in Northumberland. The reason for this came from Grace having been in Northumberland since 2009 but having had no BME clients. In December 2013, they commissioned a piece of research to look into how the organisation increased the participation of non-White British Women in their services. The research brief specified the objectives as:

1. To identify ethnic composition of women residents of Northumberland.
2. To identify BMER groups in Northumberland.
3. To identify appropriate ways of approaching individual communities with a view to identifying what support survivors might want with regard to rape, sexual violence and childhood sexual abuse.

This report presents the findings of this research and provides recommendations.

Box 1.0 Key statistics, 2011

Northumberland has a total population of 311,066, with a total of 161,904 females. The ethnic make up is:

97.2 percent White British (n=307,097)
0.9 White Other (n=2980)
0.8 percent Asian/Asian British (n=2658)
0.5 percent Mixed/Multiple ethnicities (n=1692)
0.1 percent Black/Black British (n=338).

In 2011, there was a total of 4083 females of all ages in Northumberland from BME and White Other groups, of these there was a total of 2661 women aged between 16 and 59.

Data source: ONS Census, 2011
1.1 Research methodology

The research was carried out between December 2013 and March 2014 by a sector specialist\(^1\). The research was carried out using a mixed methodology of qualitative and quantitative techniques. The qualitative methods included:

- Focus Group Interviews (FGIs) with women of ethnicities other than White British: a total of three FGIs were carried out. Three of these took place in Blyth. The ethnicity of participants included: six South Asian women; six Polish women; and one Romanian woman.
- Questionnaires completed by women in Northumberland of other ethnicities (appendix one): qualitative questionnaires were distributed at different opportunities including a multi-cultural heritage event in Blyth and through a language school in Northumberland. A number of questionnaires were designed and two were delivered. A total of 30 questionnaires were completed.
- Questionnaires completed by professionals (appendix two): questionnaires were distributed across networks in Northumberland (including those in the local authority, health authority and voluntary sector). The response to these was very poor (three responses).
- Semi Structured Interviews (SSIs) with professionals: administered face to face and the telephone. A total of 11 SSIs were carried out.
- A review of the literature and guidance concerning BME/non White British involvement in services.

The qualitative data produced by the FGIs were formatted into manageable data using framework analysis (Ritchie and Spencer, 1994\(^2\)) and constant comparative methods (Glaser and Strauss, 1967\(^3\)) were used to analyse the data to clarify meaning and examine, compare and contrast associations.

\(^1\) Barefoot Research and Evaluation, see [www.barefootresearch.org.uk](http://www.barefootresearch.org.uk)
Themes emerged from the different interviews and recurring themes across transcripts were taken to reflect shared understandings of the participants. The finding section (3.1) is structured according to those recurring themes.

It is worthy of note that it became apparent during the research that people do not like to talk about the subject matter of sexual violence. Indeed, there was a difficulty in finding women who would discuss the issue, with some women refusing and in other instances, gatekeepers refusing on the behalf of women. It is noteworthy that in the focus group with five South Asian women, they were not told about the discussion topic, because if they were, they would not have attended. 

There was a significant amount of investigative research carried out during the research. These investigations concerned canvassing opinions as well as investigating the existence of BME and White Other groups or opportunities where they meet. Contacts were made with:

- Alnwick, Berwick and Blyth CAB
- Ashington Community Development Trust
- BECON
- Blyth CVA
- CAADA
- Cease24
- Darlington Rape Crisis
- ESOL tutors (current and retired)
- Karma Nirvana
- Lancaster University, Social Work Department
- LGBT service (Trinity Youth)
- Mohr Language School
- NEPCO, Polish North East network

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4 The researchers were unaware of this until after the focus group interview had been completed.
• Northumberland County Council: Adult Services, Education, Community Safety, Economic Policy
• Northumbria Police
• Northumbria Sexual Assault Referral Centre (SARC)
• South Tees SARC
• Sunderland University, Sociology
• VONNE
• Women’s Health Advice Centre
• Women’s Health in South Tyneside

1.2 Sexual violence prevalence amongst BME and White Other groups in Northumberland

In this section, we look at what national prevalence rates tell us when they are applied to local population figures.

National prevalence

The Government\(^5\) states:

Based on aggregated data from the Crime Survey for England and Wales in 2009/10, 2010/11 and 2011/12, on average, 2.5 per cent of females and 0.4 per cent of males said that they had been a victim of a sexual offence (including attempts) in the previous 12 months. It is estimated that 0.5 percent of females report being a victim of the most serious offences of rape or sexual assault by penetration in the previous 12 months.

Around one in twenty females (aged 16 to 59) reported being a victim/survivor of a most serious sexual offence since the age of 16. Extending this to include other sexual offences such as sexual threats, unwanted touching or indecent

exposure, this increased to one in five females reporting being a victim since
the age of 16.

Only 15 percent of victims/survivors of such offences said that they had
reported this to the Police.

**Northumberland prevalence**

When these national prevalence rates are applied to Northumberland, we see
that:

- On average each year, a total of 66 BME and White Other women
  experience sexual violence (including attempts); 13 women are victims
  of the most serious sexual offences. The experience of sexual violence
  can be broken down by ethnic group as: 28 White Other women; 23
  Asian/Asian British women; 10 Mixed/Multiple Ethnicity; two
  Black/Caribbean women; two Other Ethnicity women; and one
  Gypsy/Traveller woman.
- A total of 532 BME and White Other women in Northumberland have
  been a victim of sexual offences ranging from serious sexual offences to
  unwanted touching or indecent exposure. A total of 132 BME and White
  Other women in Northumberland have been a victim of a serious sexual
  offence since the age of 16.
- According to national prevalence rates, only 10 BME and White Other
  women reported these offences to the Police

Local data from Northumbria Police shows that since 2010/11 to January
2014, 556 sexual offences were recorded. Only two victims were from a BME
group. From available data supplied by the Northumbria Sexual Assault
Referral Centre (SARC), we see that in 2010/11 they received 350 referrals,

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6 These are 2011 estimates, as they use data from the 2011 Census.
7 This is derived from 2.5 percent of 2661.
8 These take referrals from across the Northumbria Force Area
of which five percent (n=18) were from ‘various BME groups’. In 2011/12, these figures were respectively 240 referrals and five percent (n=12). Based on the number of BME reports in Northumberland, these SARC figures must be from people in other local authority areas. From both Police and SARC data, we can conclude that BME reports of sexual violence are very low.

We looked at SARC data from another area (South Tees), which had more detailed information about referrals. Looking at that data, we see in 2012/13 they had a total of 441 referrals and of these there were nine BME referrals (representing two percent). Almost half of their referrals were either in counselling or had agreed to be referred to counselling services. This demonstrates, in South Tees, that a significant proportion of all referred survivors of sexual violence require counselling.

If we extrapolate and apply these proportions to Northumberland prevalence data (66 BME victims/survivors) and if we assume counselling is an appropriate and culturally relevant service for BME groups, then we would arrive at a number of BME survivors of sexual violence who require counselling, i.e. there is a need for counselling services for approximately 30 BME survivors in Northumberland.

1.3 Ethnicity of existing client base

The percentage of non White British clients within RCTN’s total caseload have varied between six and seven percent in the years between 2011/12 and 2013/14 (figure 1.1). In the last three years (2011/12, 2012/13 and 2013/14), they have had a total of 44 women from ethnicities other than White British, with the highest numbers belonging to the African ethnic group (figure 1.2), followed by the Asian ethnic group.

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9 Michelle Sheridan, Protecting Vulnerable Persons Manager, Northumbria Police, personal communication, February 2014.
10 We used data from here as data from the Northumbria SARC was incomplete and unavailable.
Figure 1.1 Total number of clients, showing non White British clients, 2011/12 to 2013/14

Figure 1.2 Ethnicity of non White British clients, 2011/12 to 2013/14

The majority of these clients live in Newcastle upon Tyne (figure 1.3).
Clients of an ethnicity other than White British have been referred from four main sources: self referrals, health services (particularly mental health services), voluntary sector organisations and social services (figure 1.4).

**Figure 1.3 Areas of residence for non White British clients, 2011/12 to 2013/14**

**Figure 1.4 Source of referrals for non White British clients**
2.0 Ethnic composition of women in Northumberland

The most recent census data (2011) shows that 98.5 percent of the total Northumberland population is White British. The remaining 1.5 percent of the population in 2011 in Northumberland were non-White British.

For the purposes of this needs assessment, we are using a grouping of Black and Minority Ethnic (BME) groups and White Other (generally a BMER definition only includes non-white ethnic groups). The largest White Other group in Northumberland are people from Poland (important groups also included are German, Lithuanian and Spanish). Also for the purposes of this study, we are only looking at females.

In 2011, there were a total of 2661 women aged between 16 and 59 and 4083 females (all ages) in Northumberland from BME and White Other groups. Figure 2.1 shows the numbers in relation to group: the most numerous being White Other.
Figure 2.1 Numbers of BME and White Other females in Northumberland, 2011: all females and those aged between 16 and 59

Data source: ONS Census, 2011

Figure 2.2 Main languages other than English spoken in Northumberland, 2011 (male and female)

Data source: ONS Census, 2011

The data in figure 2.2 tells us two important things:

Firstly, it tells us that whilst Polish is the dominant language of the White Other ethnic group, a number of other European languages and thus
nationalities make up over half of the grouping. These are in order or magnitude: German, Lithuanian, Spanish, French, Portuguese, Russian, Latvian and Romanian.

Secondly, it tells us that there are only a relatively small number of people speaking Chinese (n=208), Bengali (n=161), Punjabi (n168) or Urdu (n=67) as their main languages in comparison to total numbers of Asian/Asian British. This tells us that the majority of this group (totalling 2658) are not first generation.

**2.1 Population locations**

In the following section, we present a series of figures which profile the female BME population in Northumberland, by ward using 2011 Census data. The data shows the following patterns.

- The highest BME and White Other female population in Northumberland is found in Ponteland and Prudhoe. Here we find the highest Asian and Asian British (n=628) female population and the equal highest White Other (with Berwick), n=161.

  Ponteland and Prudhoe has 15 percent (n=628) of the BME and White Other population of Northumberland. This is also apparent in the school population, for example, 10 percent of the Ponteland school partnership are children from BME communities, compared to 1.1 percent in Coquet.

  The next highest Asian and Asian British population is found in Ashington (n=225).

- The other equal highest White Other population site after Ponteland and Prudhoe is Berwick (n=161), followed by Alnwick (n=107).
There are other small but significant BMER female populations found in Cramlington (Asian=65, Mixed Ethnicity=61 and White Other=72) and Blyth (Asian=69, Mixed Ethnicity=33 and White Other=67).
Figure 2.3 Total female BME and White Other population in Northumberland

Data source: ONS Census, 2011
Figure 2.4 Major BME and White Other population points in Northumberland, including numbers, 2011

Data source: ONS Census, 2011
Designed and created by Barking Dog Design and Layout
2.1.1 Asian and Asian British populations

Figure 2.5 Ponteland and Prudhoe: highest Asian/Asian British female population in Northumberland

Data source: ONS Census, 2011

Figure 2.6 Ashington: second highest Asian/Asian British female population in Northumberland

Data source: ONS Census, 2011
2.1.2 Eastern European populations

Figure 2.7 Berwick: highest White Other female population in Northumberland

Data source: ONS Census, 2011

Figure 2.8 Alnwick: second highest White Other female population in Northumberland

Data source: ONS Census, 2011
2.1.3 Other BMER populations

The following figures present Cramlington and Blyth, the towns with the other significant mixed BMER populations, i.e. Asian, White Other and Mixed Ethnic groups.

Figure 2.9 Cramlington: mixed BMER female populations

Data source: ONS Census, 2011

Figure 2.10 Blyth: mixed BMER female populations

Data source: ONS Census, 2011
2.1.4 Locations of English speaking proficiency

The 2011 Census captured information on the ability of Northumberland residents to speak English. Only 0.2 percent of the Northumberland population cannot speak English well or at all (table 2.1).

Table 2.1 Proficiency in English: Top 10 wards in Northumberland with low proficiency levels

<table>
<thead>
<tr>
<th>Ward</th>
<th>All residents aged three and over</th>
<th>Cannot speak English well or at all (when main language is not English)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Berwick (East and North)</td>
<td>9047</td>
<td>89</td>
</tr>
<tr>
<td>Hirst</td>
<td>5319</td>
<td>35</td>
</tr>
<tr>
<td>Croft</td>
<td>4485</td>
<td>32</td>
</tr>
<tr>
<td>Alnwick</td>
<td>4627</td>
<td>25</td>
</tr>
<tr>
<td>Newsham</td>
<td>4554</td>
<td>23</td>
</tr>
<tr>
<td>Chevington with Longhorsely</td>
<td>5461</td>
<td>27</td>
</tr>
<tr>
<td>Ponteland South with Heddon</td>
<td>4208</td>
<td>18</td>
</tr>
<tr>
<td>Kitty Brewster</td>
<td>5269</td>
<td>17</td>
</tr>
<tr>
<td>Rothbury</td>
<td>5167</td>
<td>17</td>
</tr>
<tr>
<td>Northumberland</td>
<td>306,525</td>
<td>644</td>
</tr>
<tr>
<td>North East</td>
<td>2,506,392</td>
<td>14,324</td>
</tr>
<tr>
<td>England</td>
<td>51,005,610</td>
<td>843,845</td>
</tr>
</tbody>
</table>

Source: ONS 2011 Census - Proficiency In English (QS205EW)
2.2 BME groups in Northumberland

There are two main locations in Northumberland where there is contact between ethnic groups other than White British and services: Berwick and Blyth. These are groups of predominantly European (dominated by Polish) women (in Blyth it is a women only group, in Berwick it is a mixed gender group, although with higher numbers of women) who are supported by voluntary sector organisations.

The research identified BME and White Other groups in:

- Buffalo Centre in Blyth (Eastern European and South Asian)
- Berwick Migrants group made up of a range of nationalities, mainly Polish but also including Portuguese and Chinese
- Filipino group in Ashington (Flow), representing Filipinos working in the health and care sector (small membership)
- Culture Club at a Sure Start in Blyth (mainly Eastern European)
- Smart, an ESOL practice group in Morpeth (at the time of writing, there were three members)
- Women’s religious group at the Blyth Mosque.

There were some South Asian women that used the Children’s Centre in Prudhoe and Ponteland. These women had been approached in the recent past concerning the topic of domestic violence and this had discouraged them from returning to the Centre. The Children’s Centre manager therefore did not want us to approach these women in case this was repeated.

The ESOL service at Northumberland College have classes in Ashington. WHAC uses a South Asian volunteer from Morpeth who provides counselling to women.
3.0 Research with women’s groups in Northumberland

3.1 Focus group research

A number of themes became apparent during the course of the focus group interviews (see methodology in section 1.1). These are presented in the following section.

- The isolating nature of being a survivor of sexual violence: isolation was brought up in a number of contexts during the focus groups. For example, women felt that it was difficult for many BME women to report incidents of sexual violence because of the shame it would bring to them and their community and a fear that news would spread (particularly felt by South Asian women). For these reasons, it was felt that many women may not report incidents to the Police. This is certainly borne out by the Police figures which show very low numbers of reports from BME women (see section 1.2).

The isolation of being a victim was also related to both the nature of the individual and to the nature of the ethnic community to which they belong. One woman illustrated:

“It is a difficult thing to talk about. Some people may keep it to themselves but this is because of their personality not because of their language or where they are from.”

However, other respondents felt women were constrained by their own communities when it came to reporting. For example, one woman said:

“It is hard to talk to someone from your own community but it’s not easy to talk to a stranger either.”

Another isolating factor was related to resources and not wanting to report
in case you lost your job or you lost your family and its accompanying resources. For example, one respondent said:

“If it was your boss [perpetrating the sexual violence] and you need the money, you might not say anything about it in case you lose your job. If it was your husband and they work and you don’t, you might keep quiet because you need their money”

Another isolating factor was having no social networks and so having no one to talk to. For example, one woman said:

“It is hard to find a real friend when you move to another country. Back home I have friends I have known since I was a child. I could trust them and talk to them. Here it is more difficult to trust people, so less likely to tell a friend if something happened. Then I would go and ask a professional for help.”

- **The control of men**: a recurrent theme within the focus groups was the controlling nature of many men within different ethnic groups. This was felt by certain members (both by South Asian and non-South Asian women) of the focus groups to be an issue in both South Asian and White Other groups, although the emphasis was put on the former. However, there were other respondents who felt that Polish women for example could do what and go where they wanted without control or influence of their men. For example one woman said:

“The male influence on women is very important. If men don’t feel threatened where the women are going, they are allowed to go. But if they feel threatened, women aren’t allowed.”

Women felt therefore that in order for a sexual violence service to be accessible for all BME women, it needed to be in a venue/location that offered no perceived threat to men, such as a community or women’s centre. As one woman said:
“[It would have to be] at a community centre to avoid suspicion … one that we already go to”.

One Asian woman said:

“My husband is happy for me to come because he thinks I’m learning English … family approves of [name of community centre]”.

- **The need for cultural connectedness in the worker**: it was felt by women in the group’s that if a service wanted to specifically target different ethnicities, then workers would need to have an in-depth cultural knowledge and also to speak the language of the groups. The ability to speak the language was particularly felt to be key, especially if counselling was the therapeutic approach. For example, one woman said:

  “If you are going to have a one-to-one or telephone service, then it must be in the woman’s own language. If they need to talk about things which are difficult, they can’t do that in a different language”.

However, there was a seeming contradiction raised to this point: survivors from a particular ethnic group, may not want to talk to another member of their community for fear that they may tell others. It was also raised that there would be a potential safety risk to workers with a specific ethnicity, as they would be an easily identifiable target for perpetrators. For example, one respondent said:

  “People will know who you are, so they could easily attack you for helping, so you need to make sure the worker is safe”.

- **Language and advertising**: the issue of language was raised in a number of contexts, which related to the language of the service (see previous point) and the language of advertising. It was noteworthy that in one focus
group all women spoke excellent English. However, it was pointed out by the associated professional that the women believed their English was poor and this prevented many of them from accessing groups due to lack of confidence in their communication skills.

It was felt by some women in the focus groups that women with poorer English literacy skills were more likely to need a sexual violence service, but less likely to be able to read the posters or leaflets advertising the service. For this reason, it was felt better to have the publicity translated into different languages. Generally however, it was found that women's speaking was better than their reading and writing in English, thus the need to translate into their own language.

It was also felt to be important to have an Internet presence, which could be found easily through search engines. For example, one woman said:

"if I wanted to find the service, I would look on the Internet, I would Google rape help or advice”.

Others said:

“Some people have no support, when they are strangers in a place they do not have good friends to talk to. These people might look on the Internet”.

“Some people do not have good English and can’t express themselves properly. These people might look on the Internet for places that could help them.”

Other visible locations for publicity included:

- GPs or health centres
- Community centres and Sure Starts
- Churches
• **Service configuration and how women would like a service to look:**
  respondents said they would like the following:

  o One-to-one counselling.

  o Delivered from a centre that they already use (to avoid suspicion from family). People also said that they would use a GP surgery to access counselling, again as a means to avoid suspicion. Many of those in the focus groups only attended those community centres. For example, one respondent said:

    “*They only come here, they go nowhere else*”.

  Another said of the Buffalo Centre:

    “*This is the only place for us*”.

  It is known that the Berwick Migrant Group experiences similar feelings from its members.

  o The centre would have to be near where they live so they do not have to travel, another means to avoid suspicion.

  o Preferably, they would prefer services in their own language. Some respondents felt that the translator would also be acceptable, if they were assured of confidentiality.

  o Some women felt that they may use an email service (which Grace has recently started).

Women felt that it was key to go through a trusted and known individual with whom they already had a strong relationship. For example, the Romanian Community Development Worker in the Buffalo centre in Blyth.
• **The need for good partnership links**: it was felt by certain respondents that a BME worker would have to make good links and partnerships with a range of community-based organisations, such as schools, colleges and health centres\textsuperscript{11}. This point would reinforce the issue that was raised by figure 1.4, the source of referrals for non White British clients, i.e. that other than self referrals, the highest number of referrals came from community-based services, particularly health services and voluntary sector organisations. Thus, the need for good partnership links.

### 3.2 Questionnaire based research

Research was carried out at an event in March held for BME women at the Phoenix Theatre in Blyth. Grace had a stall at the event and during the day women were encouraged to fill in a questionnaire (see appendix one) or they were asked questions from the questionnaire which was then filled in for them. A total of 21 questionnaires were filled in by women from a range of ethnicities (figure 3.1). Questionnaires were also completed by women from Mohr language school and one survivor in therapy (four questionnaires).

**Figure 3.1 Ethnicities of research participants**

\textsuperscript{11} This is a professional-based viewpoint expressed by a part time Polish community development worker, although it was backed up by other members of the focus group.
In answer to the question, what should a service for survivors of sexual violence look like, one-to-one counselling and telephone support were the most popular responses (figure 3.2). There were broadly equal responses to the question of should the service be close to home or in another town. There were some responses in favour of group therapy and the most popular community location was in the community centre.

A total of 71 percent (n=15) of total respondents felt that there needed to be a worker from a BME background for a service which specifically targets BME women. Furthermore, the same percentage felt there needed to be a worker from the same ethnicity as the ethnic group they were targeting, i.e. a Polish worker for Polish women, a South Asian worker for South Asian women.

**Figure 3.2 What should a sexual violence service look like**

In response to the question on advertising, most women were in favour of posters and leaflets in a range of community-based locations, followed by material in churches and mosques.
Figure 3.3 How should a service be advertised

- Posters and leaflets in doctors, community centres, libraries, shops
- Posters/leaflets in churches or mosques
- Different language
- In newspaper, on radio
4.0 Literature review: engaging BME/White Other ethnic groups in the violence against women and girls sector\textsuperscript{12}

We carried out a brief review of available literature and guidance concerning BME involvement in community organisations and services. It is noteworthy that there was limited availability of such guidance, including from key support organisations in the violence against women and girls sector, such as Coordinated Action Against Domestic Abuse (CAADA).

The NHS Confederation report ‘Engaging with BME communities: insights for impact’ (2013) identifies key strategies that organisations can use to encourage greater engagement with BME service users. Key guidance points include:

- Embed an understanding of the specific needs of BME communities into the design, delivery and evaluation of service provision.
- Implement a well-defined equality vision which includes a specific action plan for engaging BME groups and then communicate this clearly to staff, partner agencies and the broader community.
- Develop further insights into the demographics and barriers faced by BME communities\textsuperscript{13} by working with other organisations and local government who may hold important data on such groups.
- Promote diversity within the workforce.
- Include the voices of BME communities within decision making processes by, for example, recruiting non-executive and lay board members from such communities.
- Use staff and service user surveys and service reviews to develop a greater understanding of the experiences of service users.
- Recognise that communities and their needs are not static and so ensure continual monitoring and communication with partner agencies and BME groups (NHS Confederation, 2013, p.4).

\textsuperscript{12} Thanks to Sarah Pelham for carrying out this review.

\textsuperscript{13} For instance, BME women may be affected by insecure immigration statuses and having no resource to public funds (Siddiqui & Patel, 2010; Thiara & Roy, 2010).
In a report on engaging faith and BME communities in activities for well-being, Age UK developed a number of good practice recommendations. To make services accessible they suggest a) distributing information at culturally appropriate venues such as places of worship, community centres and GP practices and b) considering the impact of language barriers and developing means of overcoming this (Bi, 2012, p.28).

This was supported by The Institute for Research Innovation in Social Sciences (IRISS) in the report ‘Improving Support for Black and Minority Ethnic Carers’ (2010). They identified a low take up of support by BME carers due to the lack of available information and subsequent difficulties in accessing the services. As above, the report suggests ensuring information about service provision is available in a range of languages. Further to this, some people from BME communities may not be literate in their own language. To overcome this, organisations could consider audio methods of disseminating information such as radio announcements (IRISS, 2010, p.4). In order to ensure services are culturally sensitive, Age UK suggests a) recruiting volunteers from BME communities and training all volunteers to be sensitive to cultural issues (Bi, 2012, p.29).

This perspective is also supported by IRISS, who recommend training on cultural diversity in order to avoid racial stereotyping. Approaches must recognise both different cultural norms across BME communities and from the majority community in order to develop appropriate support (IRISS, 2010, p.4).

In 2008, Refuge developed a successful Eastern European Community Outreach Project in light of the insufficient support available for Eastern European women affected by domestic violence. The project was located in London and worked directly with women who were primarily Polish, Romanian, Bulgarian. In order to establish the project they spend considerable time developing infrastructure, by creating links with statutory
and voluntary organisations and by raising awareness of the specific needs of Eastern European women.

As in the studies above, language was a central issue and the vast majority of women Refuge worked with needed language support (93 percent). Using focus groups, service users identified ways in which the current project could be developed further and key suggestions included: a) trained counsellors who speak Eastern European languages; b) support and therapeutic groups for women to share experiences and reduce feelings of isolation; and c) access to accountants and solicitors at surgeries (Thiara, 2011, p.34).

The Southall Black Sisters Trust report ‘Safe and Sane’ (2010) outlines a holistic model they developed in order to provide specialised services for BME survivors of abuse. The model combines advice, advocacy and support services with counselling and psychotherapy. Due to the high success rate\textsuperscript{14}, they suggest this should be replicated by Primary Care Trusts operating in areas with high BME populations. Particularly, they highlight the value of a ‘hybrid’ model of psychotherapy which combines humanistic, cognitive-behaviourist and psychodynamic therapies in a fluid way, alongside Life Coaching (Siddiqui & Patel, 2010, p.7). This allowed for the relaxation of boundaries and greater flexibility in communication, in order to meet the specific needs of BME women. Central to this approach was also a need to recognise the specific impact of religious and cultural pressures, evident in notions of ‘shame’ and ‘honour,’ and of racism on the experiences of BME women which may elevate the risk of Post-Traumatic Stress Disorder. They cautioned against some counselling services that undermined best practice by using religious leaders or clerics to ‘advise’ on counselling or too provide ‘alternative’ forms of counselling for members of BME communities. These practices often reinforced conservative values and practices justified in the

\textsuperscript{14} The Project assisted 3380 women over eight years and had a success rate of 82 percent in a sample of 89 cases and 94 to 96 per cent in counselling which helped to reduce the incidence, or the effect, of domestic violence and mental health problems, including suicide and self-harm. Success rates were measured by a number of factors including low repeat victimisation rate and a greater sense of safety and well-being.
name of culture or religion, which prevent women fleeing or challenging domestic abuse (Siddiqui & Patel, 2010, p.89).

Box 4.1: Lessons from Women's Health in South Tyneside

WHiST is a multi-purpose and therapy and activity women only community centre based in South Shields In South Tyneside. Several years ago they recognised a need to attract more women from BME communities and so they became proactive to address this. They have been successful and now have a BME group and individual women that use their centre. We interviewed the manager to ask her what are their success was due to. This is the results of the interview:

Question: You say you have changed your ways of working in some ways to improve involvement, how have you done this and in what ways have you changed?

Answer: We have for instance placed more volunteers in with the BME group, and we have held consultation days with the group to try to encourage them to express their needs. We have also had crèche workers from the Angelou Centre attending our crèche to support our workers and build the trust of the BME women and children. We held cultural events around fun things like henna painting and massage to attract the women initially. We set up joint meetings with key workers and agencies supporting BME women in the borough.

Question: How do BME women find out about you, from word of mouth or from those BME organisations you mention that you have links with.

Answer: Word of mouth works best … women bring relatives and friends.

WHiST has tried and succeeded in engaging with people from BME groups, bearing in mind you are not a BME organisation, this is a great success.

We still have a long way to go. We found that when we had an Asian woman in the office on work experience we had an increase in Sikh women calling in, when she left they dropped off.

We are still trying to work closer with Apna Ghar [a local BME organisation) to encourage BME women to accept WHiST as a progression route for women wanting to integrate.
5.0 Conclusion and recommendations

5.1 Conclusion

There are a number of key findings which arise out of this needs assessment. These include:

- There are small but significant non White British populations across Northumberland, with concentrations in the west, south east and north of the county. The most populous ethnic groups are South Asian and Polish.

- Reporting of sexual violence amongst BME groups is very low and confidence to report incidents also appears to be very low. There are subsequent low numbers of BME women who attend SARC services.

- Despite these low numbers in real terms, national prevalence percentages indicate that there are non White British people in Northumberland who are victims of sexual violence. Also, using regional percentages of the numbers of survivors who received or were referred to counselling services, we see that there are non White British survivors who may require counselling (see at the end of section 1.2). In other words, although hidden, there are non White British who may require an intervention from RCTN.

- There are only two regular meeting points where non White British women congregate on an ongoing basis; in Berwick and in Blyth. There are looser accumulations elsewhere including Children Centres in the west and east and in the ESOL classes of Ashington College.

- There was consensus on common elements for a service suitable and targeted for non White British women and these elements included:
  
  - A one-to-one service.
Delivered by a worker who was of the same ethnic background of clients and who spoke the same language.

Delivered from a local community-based centre which was already used by non White British women and during school times, i.e. after 9:30am and before 2:30pm in term times.

Advertised in both community venues and on the Internet in a variety of different languages.

- Relationships and trust are key to disclosing incidents of sexual violence amongst non White British women.

Outside of these conclusions, we feel it is important to note a general low awareness of issues relating to violence towards women in Northumberland. We attempted to engage with different representatives from the Health Authority on this issue with little success. Also in discussions with local community-based workers, we found a general low service awareness of issues relating to sexual violence and local populations, both BME and non-BME populations. It would appear that this issue around service awareness needs to be tackled on a strategic level within Northumberland. This would best be achieved through the appointment of a strategic lead for violence against women and girls.

5.2 Recommendations

Based on these findings from the previous section, we make a series of recommendations for RCTN. These are:

- A programme of regular visits should be started at the BME meeting points in Northumberland and should take place on at least a six monthly basis. The objective of this activity would be to develop relationships with BME leaders and gatekeepers. To illustrate this recommendation, we refer back to the focus groups where although some women said that they would look on the Internet or look at other advertising points in the community, the
majority of respondents said their preferred method would be to tell a trusted community worker, who could then access services for them. Thus, the key task of RCTN is to develop relationships and gain the confidence of those BME leaders and gatekeepers, as these where the BME referrals will come from.

- Similarly, a parallel programme of visits should take place across community-based agencies, to raise awareness of the issue of low reporting and a therapeutic need amongst BME communities. This is based on RCTN figures from outside of Northumberland, which show referrals of non White British women being made by such services, including health (particular mental health) services and voluntary sector organisations.

- RCTN has already invested considerable resources in translating advertising and publicity materials. However, in view of the findings of this needs assessment, the translation of advertising and promotional materials should be re-examined and re-drafted to include information about the universality of RCTN’s services and to emphasise the fact that survivors do not need to report to the Police to be able to receive their service. During the research, there was an appreciation that some non White British women felt that services in the community were only for residents and not for them. It was also thought by some respondents that services were only available if a report had been made to the Police. Such information and directions to the service must be made available on the Internet as well as in the community venues identified in this research.

- A BME focused project/initiative can be constructed using the information in this needs assessment. It would seem sensible, because of low numbers (in proportional terms, i.e. because of an absolute lower number of non White British populations, there would be a lower number in real terms of prospective clients) to share such a service across the entire RCTN geographical area. This service would employ a South Asian and
an Eastern European female worker (either full or part-time) to deliver services.

- There are several issues which arise from the guidance literature around BME involvement, some of which having already been started, such as a translation of advertising materials and involving volunteers from BME communities and others which are recommended from this assessment, such as the placement of publicity materials in faith venues. A key point from the literature is the need for involvement of BME representatives on their strategic governance arrangements. We would advise adding a non White British woman on the Northumberland Advisory Group and the RCTN Board. It is good practice to have a range of ethnicities within strategic management to ensure representation at the heart of the organisation. There are other recommendations that arise from the literature, although many of these relate to resources and capacity, such as: developing service user groups; and developing group based support.

Based on the absence of any good guidance for organisations wishing to increase the involvement of non White British clients/service users, particularly in the violence against women and girls sector, it would be remiss of this research if we did not recommend that guidance needs to be produced and widely made available to enable an equitable service provision.

- RCTN already carries out awareness raising and training work in Northumberland about sexual violence. However, we recommend that targeted awareness raising work and training needs to take place across Northumberland to raise the profile of sexual violence within BME/non White British communities. This is a wider piece of work, which implicates local strategic authorities (health, community safety and local authority) but must go hand in hand with any initiative that attempts to increase the numbers of such clients in services. Grace is in a good position to lead this, either as a specific piece of work or by embedding the subject in
existing awareness and training activities.

Finally, we would like to end with a recognition that the organisation has a proven track record of engaging with BME populations in Newcastle. However, in Northumberland, there must also be a recognition that engaging with and delivering services to non White British survivors will be a long and slow process, given the current low reporting, low service awareness of the issue of sexual violence and limited meeting points of such populations. Thus, if any targeted initiative is started, it needs to be given good time to become established and achieve results.
Appendix one: Questionnaires completed by women in Northumberland of ethnicities other than White British

Sexual violence includes rape, sexual threats, unwanted touching, indecent exposure, forced bodily contact and female genital mutilation.

1. What do people do when sexual violence happens?

Go to the Police
Tell their friends
Tell someone else (like who ........................................)
Do nothing
Other – please say ........................................................................................................

2. What do you think a service to help survivors of sexual violence should be like?

One-to-one counseling/talking
Group therapy
Email support
Telephone support
Drop in, e.g. community centre
Close to home Or in another town?

Would you need a worker from your own culture that speaks your language? Yes/no

3. How would you find out about the service?

From your GP or health centre
From a community centre worker
From a friend
From the Internet
Other – please say ........................................................................................................
Appendix two: Questionairres completed by professionals in Northumberland

Grace is a Northumberland charity that provides counselling, support and information to women and girls over 16 who have been affected by rape, sexual assault or sexual abuse, at any time in their lives.

Grace has been operating in Northumberland since 2009. They now provide counselling to around 70 survivors a year. However, there has been no women coming forward from black, minority, ethnic or refugee (BMER) communities.

Grace wants to engage better with BMER communities in Northumberland and make sure they are doing everything they can to reach out to all.

We would like to know:

1. If you are aware of any occasions, events or services which are attended by BMER women in Northumberland: what and where are these and who attends? (theses can be such things as mother’s and toddler groups, college classes, school events, etc.).

2. What do you think the best way is of engaging with these groups, or letting them know about the services of Grace.

3. If you have any other ideas or thoughts about bringing Grace’s service to BMER women in Northumberland.

Please email your responses to Joanne Hartworth from Barefoot Research and Evaluation on: joanne@barefootresearch.org.uk

We thank you very much for your time and consideration; it is invaluable to supporting women affected by rape, sexual assault or sexual abuse.
References


CVABV, 2010, Closing the Gap: Effective Engagement with Northumberland Black and Minority Ethnic Communities in Influencing Public Services, Northumberland county council, NCDN, NEEP


