‘Cultural Competence’ -- ‘Know The Culture and you will Know the Person’

Changing preconceptions -- Enhancing service Provision

A Guide for Social Services managers and frontline staff relating to and engaging with Black and Minority Ethnic [BME] service users

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Your voice on local health and social care

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NHS BME NETWORK
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DORSET RACE EQUALITY COUNCIL

Contents

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Alan (who is of dual British-South American heritage) was commissioned by the Dorset area LINks [Local Involvement Network] organisation in autumn 2012, to create the material that forms the basis of this information resource. He has extensive experience, developed over a number of years, in supporting and representing the healthcare and broader needs of UK BME communities (in particular the Dorset and South Coast Chinese community, and more recently, at a national level, the UK Nepali community). In being requested to create the Social Services BME communities engagement resource, he has throughout developed the information provided from the perspective of BME social services (and NHS) customers/users, with the latter's direct involvement in shaping the material provided. In so doing, the resource breaks new ground, and it is to be hoped will be invaluable to social service organisations through both the information provided, and the opportunity to listen to the 'voice' of BME individuals perceptions about the services they receive, and how these are commonly presented to them from non-BME social services frontline staff.

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Dr Rajeeb Kumar Sah: PhD Scholar, Canterbury Christ Church University. Dr Sah, in addition to providing a comprehensive review of the final state material contained on this information resource, also provided valuable details for its health matters component (Section 10) and advised the creation of the sexual health section of the resource (Section 11) and provided its content. Dr Sah was also responsible for rationalising the final state order of the resource's main contents index.

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PART 1

1. Introduction and Using the Resource

The United Kingdom is a multicultural and multiracial country, yet public service organisations have considerable work to do to demonstrate awareness of this reality: BME communities particular needs and the strong and positive contribution they make to the life of the nation and broader society being all too commonly overlooked. The resources of this information pack have been provided to help address this problem and to contribute to more effective social services engagement with BME communities in the Dorset, Bournemouth and Poole area.

Individual contributors to aspects of the material provided in the resource range from senior officers of social services departments in the Bournemouth, Poole and Dorset, to BME community group leaders and BME service users. In addition relevant data and details are included from national reports created by national BME community supporting and representational organisations (such as the Afiya Trust); whilst valuable input has been provided by Dorset Race Equality Council.

Contents:
The information pack provides an overview of issues commonly faced by both BME individuals accessing or seeking to access or know about social services and the corresponding communication and care provision issues that arise for social services officers seeking to provide better access to BME individuals using or seeking to use their services.

Section 2: provides valuable information that can assist in developing greater meaningful/practical awareness of multicultural/multiracial Dorset, Bournemouth and Poole.

Section 3: focuses upon the challenge of social services across the county and Bournemouth-Poole conurbation being aware of characteristic challenges of outreach to BME communities and the securing of the trust and confidence in social services provision of individuals from those communities.

Section 4: covers a number of thematic areas of potential direct benefit to social services staff officers (frontline and senior officer levels in particular) in the Dorset, Bournemouth and Poole area: the material provided being selected to enhance practical-level awareness of issues that inhibit BME communities confidence in accessing and using social services.

Using the resource:

The information pack can be used in two separate ways:

- As a BME communities profile thematic information resource that looks at specific topics, enabling practical level cross-cultural learning to take place
- To encourage reflective thinking about the issues and challenges that BME individuals commonly face to varying degrees in accessing and receiving equitable and friendly treatment from social services frontline staff

Study of the resources will reveal that multicultural learning and multiracial awareness are absolutely essential for social service staff to function effectively and professionally. Similarly the material provided in Section 4 of this guide will likewise assist in reducing 'one-size' fits all assumptions by non-BME social service staff about BME communities and BME service users / customers. Sections 3 and 4 can be used respectively as:

a) a basis for equality and diversity training such as discussion sessions
b) an overview of useful facts that whilst generally valuable, can also be used for the relevant area that the member of staff engages in (carer-related, disability support, etc)

2. Challenges posed to social services in engaging effectively with BME communities: some guidelines to enhance engagement

Avoiding stereotype thinking and perceived indifference:

'One in five local authorities failing BME communities by ignoring equality legislation' [1]

'Reduce the 'one-size-fits-all' approach to BME service users, which often results in adverse social care and healthcare outcomes' [2]

Two particular challenges are experienced by social services in effectively relating to members of BME (Black and Minority Ethnic) communities:

a) The combating of thinking and relating in stereotype-driven 'one-size-fits-all' ways
b) Avoiding unawareness/indifference to the special additional factors – including the impact of racism -- that limit effective, friendly and professional engagement with BME service users in comparison to those with the majority non-BME community

The biggest challenge faced involves breaking into a substantial awareness of the scale of diversity of needs and particulars of BME individuals that use or are entitled to use and will benefit from the very extensive range of services that social service organisations provide. These diverse needs and particulars defy and contradict mistaken assumptions of a stereotyping and labeling kind that stand in the way of social services being properly understood by and receiving the confidence and trust of BME individuals: African and Caribbean LGBT's as a seldom heard vulnerable and marginalized group being an important example.

The due to a 'getting the job done and over with as quickly as possible' mentality -- rather than the actual professional best practice 'know the service user not as a job lot with only a certain amount of time/minutes allocated, but as a fellow human-being' perspective – is one that in reality still needs to be tackled by social services organisations.

For the indifferent and uncommitted, the slavish devotion to stereotype thinking is ever an excuse to avoid professional dedication: this occurs and has ever occurred in both public service organisations and private companies. The removal of such thinking is a major personal challenge to a minority of such individuals, since it also takes away excuses to apply themselves more effectively and professionally.

Poole Borough Council Social Services guidance and reflections provided as a result of their experience and working practice:

Understanding a service user's reticence to engage in services because of previous racist attitudes of staff (for example) can enable an open dialogue about the service user's needs and how best their needs can be met. Gaps in services delivery must be identified and a mechanism for collating and addressing these must be in place. Otherwise service users are offered a particular service regardless of their individual needs or wishes. Sometimes small adjustments can address preferences.

Some practitioners will be hesitant of asking questions or revealing their low level of understanding of BME communities for fear of appearing racist or ignorant. However, social service workers will possess skills for sensitive questioning of a number of issues, including health and welfare and it is important that they have the confidence to use these skills to explore the impact of the person's experience on their well-being and the choices they make.

In Safeguarding practice social workers are obliged to put the protection of vulnerable children and adults first. However, where there are cultural implications to the risks they face there is a balance to be achieved between understanding the culture, faith and experience and addressing risks. Open dialogue is the most effective way of addressing this challenge and there are a number of resources available to practitioners to check cultural expectations.

All assessments undertaken seek to understand the individual's circumstances and experiences and so have scope to capture the key elements of the person's diversity.

Useful links:

1. One in five local authorities failing BME communities by ignoring equality legislation
http://www.carersuk.org/newsroom/item/2490-one-in-five-local-authorities-failing-bme-communities-by-ignoring-equality-legislation-claims-new-campaign-by-health-charity

2. Living in the Margins: www.livinginthemargins.org

Guidance notes:

It is valuable to have awareness in engaging with service users from BME communities that there may be said to be four distinct groups that broadly comprise the spectrum of BME individuals that interact with social services. The first have minimal (yet still some) difficulties with accessing services, whilst the remaining three ‘seldom heard’ ones have substantial needs:

a) Westernised BME individuals: complete familiarity with and ease of accessing social services, yet occasionally subject to lack of professionalism due to race and culture bias from staff on the grounds of colour of skin and intonation
b) Older, less Westernised BME individuals with limited English language skills
c) Invisible / ‘seldom heard’ BME sub-groups: mental health, LGBT, disability (especially learning disabilities)
d) Migrant / new residents: restricted English language skills and minimal awareness of social services provision and how where appropriate to access them

Awareness of these four specific BME population groups will greatly assist in overcoming any ‘one size fits all’ assumptions in relating to BME communities and in particular encourage more individual-level engagements with BME customers of social services.

Beyond awareness of the particular perspectives, contexts and needs/challenges faced by these very different core BME groups, social services frontline staff also need to understand the scale of the negative impact of direct and indirect racism, and race/culture-based discrimination, upon BME individuals using or seeking to access social services.

PART 2

Some main thematic topics and issues inhibiting outreach and engagement with BME communities:

This the main section of the information resource provides an overview of thematic areas that will aid social service organisations managers and frontline staff to have a fuller understanding of cultural factors and related practical issues of importance in engaging effectively with BME social service users (whether or not influenced extensively, minimally, or not at all by traditional cultural perspectives and related values).

1. **Some common perceptions about 'social services'**
2. **The impact of racism and related discrimination**
3. **Cultural barriers – some examples**
4. **Linguistic barriers**
5. **Accessing services to safeguard children and adults**
6. **BME women's needs**
7. **Needs of the elderly**
8. **Carers and 'Caring'**
9. **Domestic violence**
10. **BME communities Long term medical conditions, health trends and diet considerations**
11. **BME Sexual Health**
12. **BME Mental Health**
13. **BME Lesbian Gay Bisexual or Trans's [LGBT]**

1. Some common perceptions about 'social services':

'Carers from minority ethnic communities are rarely the focus of social work assessment and support'

'Service users from minority ethnic communities are dissatisfied with the opportunities, modes and levels of influence they had in user involvement activities …'

'… Workers are perceived by the [BME] community as "do gooders", not taken seriously'

'Women don't access services for fear of their children being taken away from them'
Source: Surviving Abuse: the BME woman's perspective: Practice Development Seminar Report. 2006.

For reasons of lack of BME cultural awareness/competence by a small minority of [non-BME] social services staff, there occur from time to time very negative experiences in areas of different normative standards and perceptions concerning for example breastfeeding and child care: it is not uncommon in some BME cultures to find it acceptable to continue breastfeeding until the age of two, and in some cases even three years of age. When such culture clashes occur, enormous damage is done to not only individual BME families, but also – as detailed above – to relations between social service organisations, and staff per se, and BME communities. Greater cultural awareness and elimination of stereotype thinking in relating to UK BME citizens can do much to overcome such negative and harmful results.

As a general rule, BME parents in caring for their children follow standards of the highest kinds and commonly exceed those followed by the vast majority of the non-BME general population. BME parents for example quite commonly will bring their children – unless they can be otherwise cared for by grandparents and other family members -- with them to daytime meetings, rather than leave them at home unattended. In this they gain a parent-to-child bonding benefit, and exercise a parental responsibility, that exceeds those of many parents in general/non-BME society who pay substantial fees to childcare nurseries because such direct care for their children is of a lesser priority than career and work occupation priorities.

The Over 50's African & Caribbean Lunch Club: experiences and observations:

This unique and valuable social and community meeting facility for people over the age of 50 of African and Caribbean heritage is highly popular, demonstrating the need for more such clubs for BME people, and how social services can play a valuable part in outreach to more seldom heard groups within the broader BME community. The Lunch Club receives social services referrals for new members to join, and is based in a Bournemouth Council community centre at Boscombe, and meets once a month.

Perceived issues indicate that day centre venues as a general rule are informed by a 'one-size-fits-all' non-culturally capable approach regarding understanding and engaging with BME needs. However, in the case of the day centre that hosts the Lunch Club, whenever such issues have arisen, they have been swiftly resolved to the benefit of staff and service users alike. The presence of the Lunch Club at the venue therefore constitutes a unique example of both best practice and meaningful cross-cultural learning.

- Lack of world cuisines diversity in food available more generally
- Staff are generally very helpful and supportive to the Lunch Club and its members, and when occasionally instances of a lack of cultural capability have been experienced, their resolution has always broadened cultural understanding
- Greater ethnic diversity in staff would be helpful, yet this does not hamper best practice standards being applied
- Accidental admittance on one occasion of a non-BME person who acted insensitively in relating to the Lunch Club in a seemingly purposefully intrusive way

The advised solution to all such issues is a simple one: 'Know the culture, then you can know the person!'

2. The impact of racism and related discrimination

Unless one has experienced it as a victim, it is difficult to explain the depth and breadth of the harmful psychological harm of experiencing racism. Clinical depression, lack of peace of mind, anxiety and repressed anger are just some examples of the costs to victims of racism; others include inability to focus on work, and being dispirited in workplace contexts where those responsible for oppressing them through verbal and sometimes physical racial abuse work alongside them and are sometimes their superiors.

Examples of racial abuse can, for example, include complete strangers intruding the most hurtful, malicious and ignorant views and behavior, suddenly at unlooked for moments. Commonly this can evolve around doing the most possible to unsettle fellow UK citizens on the grounds of their being of a different cultural background, the colour of their skin, or the religion that they follow -- and then making the charge that BME people are not 'true British' and 'don't integrate, but keep themselves closed off by choice from the 'real British people,' etc.

Social services frontline staff, for reasons of professionalism and effective engagement, have to be fully aware of the scale of the negative impact upon BME individuals using or seeking to access their services, of both overt and more subtle racism, and perceived discrimination on grounds of race/culture/ethnicity.

'Out of a survey of 153 international postgraduate students, 49 had experienced some form of abuse. In most cases, this took the form of verbal abuse though racism manifested physically for nine students. Strong emotional reactions were reported, including sadness, disappointment, homesickness and anger. There was a consequent reluctance to return to the UK as a leisure tourist or to offer positive word of mouth to future students. This article offers a portrait of the reception offered to international students against a backdrop of increased racism in the UK …'

'The BBC survey (2010) also probed in depth participants' perceptions of racial discrimination in education and at work, and revealed that almost one-third of blacks and Asians said they had faced racial discrimination at school, college or university, compared with 1% of whites. Similar proportions of black and Asian respondents said they had faced discrimination at work, compared with 3% of whites. Whilst 28% of whites thought colour affected how individuals are treated in education, 48% of blacks and 42% of Asians subscribed to that view. When it came to work, half of black and Asian respondents thought colour made a difference to how they were treated, compared with one-third of whites.'

Because -- as the above details concerning international students indicate -- racism in the UK remains a widespread phenomenon that is still largely challenged and combatted ineffectively, social services frontline staff and senior officers can only meaningfully engage with BME service users if they take the substantial negative impact of actual day-to-day racism and related discriminatory treatment into account.

Where people experience prejudice it can affect their and their family's and friends' lives, as well as the wider community. Evidence shows that hate crimes, targeted at a person because of who they are, have a much greater impact on their well-being than on a person of a 'non-targeted crime.' 92% of those that experience hate crime are emotionally affected compared with 86% of those affected by other types of similar crimes. 67% compared to 60% feel angry; 39% compared to 14% experience fear; 23% compared to 6% experience anxiety/ panic attacks; and 20% compared to 6% feel depressed

Racism takes place at two core levels. There is overt verbal and physical abuse racism, and there is the yet more harmful and extensive form of discriminatory behaviour racism. This latter is of especial importance to professional and inclusive social services organisations and their frontline staff (visitors to homes of service users; telephonists; receptionists; staff in community centres, etc). It is valuable to consider the cross-cultural learning benefits of prejudice incident reporting as a mechanism of enabling people to talk about their experiences and to seek a way of addressing the abuse they have experienced.

Discriminatory racism is as subtle and insidious as it is destructive. It concerns 'cold facial expression and cold language,' minimal or overtly uncommunicative and unhelpful verbal/conversation exchange of the 'don't know what you are saying / speak proper English,' 'sorry, can't help you' kinds.

Racial discrimination of these insidious kinds are only practiced by a quite small minority of individuals from the main white non-BME population, yet it takes place in a very extensive range of commonplace settings: from bus drivers and shop assistants, to GP surgery receptions.

It requires little imagination to understand that these instances of all too commonplace race/culture/ethnicity forms of discrimination cause the majority of UK BME individuals to feel 'unwanted' and to be 'second class citizens' in the UK. Consequently, an unspoken and unofficially [by public service organisations, such as social services] recognised 'apartheid' mentality of a small yet very non-inclusive minded minority of the majority white non-BME UK population causes substantial harm to the general outlook and psychological well-being of BME UK citizens.

It is not realistically possible therefore for social service organisations to effectively relate, at a general level, to BME service users without some prior awareness of the extent of the negative impact of overt racism and more subtle and insidious race/culture/ethnicity based discrimination.

Many social service practitioners will have received training on these issues in their professional training, but it is in practice that they can explore people's true experience of discrimination and the impact of it. Reflective practice in social services is encouraged and opportunities to reflect on the experience of BME families is crucial.

Opportunities to hear feedback from service users is often built into service provision and development: this really for credibility purposes should be a mandatory requirement as fundamental as for example health and safety provision and procedures. It is important that BME groups are involved in these consultation processes in a way in which they can make open contributions. Without such involvement the organisation demonstrates lack of seriousness around all forms and levels of inclusion and equitable treatment of its staff and service users, with statements about equality and anti-discrimination being mere empty rhetoric required to 'tick boxes.'

3. Cultural barriers – some examples

Know the culture and you will better know the person

The costs of 'not making a fuss':

It is so important for social services staff to understand that in some cultures it is regarded as the norm to tolerate matters that can be distressing, such as discrimination and even different types of bullying and intimidation: the psychological and social costs of 'not making a fuss' are therefore grave, and it is invaluable for social services officers to be aware of this, to know the signs and to offer tactful and appropriate (sensitive and polite/considerate) guidance.

Reporting prejudice incidents:

To explain that there are facilities for service users making complaints, if required due to perceived or actual poor/unprofessional treatment, is a part of all public service organisations work: practical information provision by social services organisations and frontline staff concerning easy to understand criteria about unprofessional conduct and the means to make complaints that will be received and responded too, is therefore as important to provide as part of the 'contract of trust approach between the social service organisation and those who use it,' as the actual service provided.

Removal of shoes on entering a home:
In many BME cultures the removal of shoes on entering the home is the norm, and shows signs of respect for coming into the private space of the home as a guest: refusal to remove shoes conversely shows disrespect for the individual and destroys their confidence in the visitor being a person who respects their culture, and ultimately therefore one who does not wish to engage with the BME individual and/or his or her family in a professional and individuality respecting way.

Eye contact:
Some BME cultures regard relaxed and natural eye contact as a sign of mutual respect, friendliness and honesty, whilst in others direct eye contact of a 'staring kind' is regard as invasive and deeply disrespectful (in the case of the latter an example would be a male social service officer engaging with a Muslim woman who follows traditional strict Islamic social interaction values).

There are numerous other areas of behaviour, values and perspectives that it is valuable for social services senior managers and frontline staff to be aware of in engaging in respectful/effective ways with less Westernized BME UK citizens: these are covered under other headings in this section of the resource.

However, it is particularly valuable to conclude the 'Cultural Barriers' part of this resource with a more extensive coverage of issues surrounding disability, since it directly relates to a substantial part of the important and valuable that social services organisations lead on at local and national levels.

Disability:

An estimated 80% of young disabled people encounter prejudice and/or overt bullying in school contexts, and disabled people (of any age) more generally commonly experience insensitivity to their needs (and not infrequently de-facto discrimination) in such day to day activity areas as using public transport. The EHRC [Equality and Human Rights Commission] report 'Hidden in Plain Sight' (September 2011) provides valuable information about the scale, nature and harm of anti-disabled bullying and prejudice.

It should be noted that greater awareness of these very unpleasant realities of general discrimination against the disabled [and therefore vulnerable] place in a proper perspective comparison with the influence of traditional cultural taboos around disability that influence some sections, of some BME communities to an ever-decreasing extent.

Historically speaking, in some traditional BME cultures disability is regarded as something that is – as with mental illness -- taboo, little referred to and commonly regarded as a result of negative fate that can only be tolerated by the disabled person as his/her lot in life.

It is most important for social services to be aware of this, so as not to judge those BME families and individuals that are still influenced by such traditional non-Westernized perspectives. There is a great difference between the endemic problem of bullying and discrimination against disabled people in general non-BME society, and the very different particular non-hate driven impact of traditional cultural taboos concerning disability that exist to a decreasing extent in some sections of BME communities in the UK.

At the same time, it needs to be recognized by social service staff at all levels, that many BME families and individuals do not subscribe to the traditional taboo respective around disability: on the basis of 'one-size-does-not-fit-all' awareness of actual different [traditional and contemporary] perspectives of BME individuals about disability, no ready assumptions should be made, tact and awareness of the individual context should always be paramount in relating to BME individuals who suffer from learning or physical disabilities, and of the perspectives and circumstances of their immediate family members (who are almost invariably those who provide direct care for them).

An example of the tact and cultivation of awareness required concerning practical support for a disabled person leaving and returning to their home:

'A BME family who had a physically disabled daughter changed their home location. Their home in the new communal building was not on the ground floor and there were no disabled access facilities at the location. This practical matter was revealed by the social services transport department when their bus called to take the physically disabled daughter to a day centre [she had been using the latter for some time to help with some of her needs]. Due to traditional taboos around the issue of disability in the perspectives of the decision-makers/leading figures in the family [who knew no other values/understanding than the traditional ones of their culture], there had been no approach to social services or the council/housing association involved in the move, regarding the disabled daughter's practical access issues on entering or leaving the new home.'

It would be easy, but actually very wrong, for the blame for this practical transportation difficulty to be attached solely to the family members responsible for the direct care of the daughter. In practise, there would appear to have been a problem with coordination between the local council's housing department and social services in regard to the allocation of the new home to a family that had a disabled member who would and did face practical access from and return to issues regarding the new home/building location.

Learning Disabilities:

'The Scottish Consortium for Learning Disability (SCLD) conducted the What's Out There? Project (2010) to find out about support services for people with learning disabilities and their families from black and minority ethnic communities.

Their research found that: 'whilst it may be challenging for most organisations to work effectively with people with learning disabilities and family carers from the back and minority ethnic communities, the Chinese and African and Caribbean communities were cited as two particularly hard to reach communities.'

4. Linguistic barriers:

The case of a Bournemouth Social Services BME community service user whose partner had to return for a period of time to their country of origin

The person in question had minimal English, and was vulnerable because of their health condition (mental/physical/disability?), and was being supported by social services for certain of their support needs due to their disability/health condition. Because their partner (with much better English, and who was in a direct carers role for the person in question) had to be away from the UK for a period of time, the person was suddenly placed in a position of understandable isolation and vulnerability.

An example of major procedural and practical level service provision failure concerning extreme distress experienced by an elderly lady from a BME community who had to go to hospital for tests without her carer or any supportive family member. The lady in question had no spoken English, had poor eyesight and was severely deaf. Her glasses and hearing aid were left behind when the ambulance crew picked her up: moreover they did not have an interpreter and no interpreter support was provided for her at the hospital.

It is frightening to imagine what the lady felt through undergoing this experience, and equally difficult to overestimate the scale of the complications involved for the ambulance staff crew members, and subsequently the staff at the hospital department where she underwent tests. The lack of clear sight, hearing and ability to express concerns or ask important questions at the hospital when she underwent the tests, must have been clearly very distressing and frightening.

A judgement must be made about when it is appropriate to use a family member to assist with translation and when it will be important to bring someone independent of the family network in to assist.

However, the right linguistic and cultural support can have a positive impact for BME service users who require support from Adult Social Care. One such example is of a Poole Social Care user who had no understanding of English. The social worker identified this issue and spent time locating an interpreter who could both empathise with the needs of the person in relation to their disability, as well as assisting with communication and cultural differences. The interpreter together with the social worker, worked with the family and the person to complete a full assessment of their needs. This resulted in a 1:1 support worker being employed who could speak both the persons own language and English to further support the person and their family.

Dementia: as a characteristic of short term memory loss, BME individuals of first generation UK residency, commonly revert to use of their native/original non-English language. This makes communication with people suffering a degenerative health condition especially difficult progressively in contexts where engagement with them (such as their communicating health needs, medical condition details, day to day living issues and challenges) is crucial to evaluate their changing/increasing need for support as their medical condition deteriorates.

5. Accessing services to safeguard children and adults

‘Research shows that Black children and those of mixed heritage are more likely to be subject to ‘child protection plans’ and/or end up in the care system than white children. The reasons behind this are still unclear, but we do know there are certain cultural [including UK social care perspectives] issues, sourced in as yet poor BME residents-social services effective dialogue, that impact sometimes controversially on the safeguarding and wellbeing of BME children and a proper, clear and effective understanding of the remit and perspectives of social service organisations in this area.

As well as Black and minority ethnic families facing similar pressures of family life as other families, it is more likely that some BME families could face extra stress due to poverty, poor housing, unemployment and low income, immigration issues, language difficulty, mental health issues or discrimination. They may also lack awareness of or access to, appropriate services which could help them.

There are cultural differences in raising children - what might seem acceptable in one family or community may be deemed inappropriate in another. Some parents, particularly those who are new to the UK, may be confused about what is acceptable practices in the UK context and this may lead to questioning by various agencies about their parenting style and in more serious cases, investigation by children's services or the police. Some cultural practices are against the law in the UK, such as female genital mutilation.

`Culture' is no excuse for harming a child. All children have a right to be protected from harm and we need to be clear about the difference between culturally specific practice that is not harmful, and incidents of abuse that may be linked to cultural or religious beliefs.

Children from minority ethnic backgrounds may suffer other types of abuse such as racial harassment, 'Islamophobia' and bullying which can harm them physically and emotionally. We need to be alert to the possibility of this happening to children who use voluntary and community sector (VCS) services, so that we can act to protect and support them. We also need to be aware of any situations where children using VCS services engage in racist bullying towards others, so that we can be clear with them that this is not acceptable and can deal appropriately with the situation.

Workers, whether from the VCS or statutory sector, who do not value diversity or have the competence to work with diverse communities and rely on stereotypical views are likely to do more harm than good when working with BME children and young people. Workers also need to be careful not to ignore concerns in favour of respecting difference or fear of being called a racist. These issues obviously have implications in terms of the training and support offered to staff and volunteers.'

Source: 'Safe Network' website article 'Supporting your work with children from Black and minority ethnic communities'
Link: http://www.safenetwork.org.uk/training_and_awareness/Pages/black-and-minority-ethnic-bme-communities.aspx

'BME parents, like the vast majority of parents, aspire to care for their children to the highest standards. Furthermore, the concept of placing a child in nursery care may be quite alien to those from societies in which this role is fulfilled by the extended family, or there is greater flexibility to combine work and childcare responsibilities.' Jane Jones: Community Development Officer. Dorset Race Equality Council

Breastfeeding and maternity support: a cultural clash and an ethical responsibility challenge:

There exists still at this time a gulf vast and controversial between legislation and directives that govern frontline social services officers interaction with UK residents from many BME communities, and the natural and culture derived practice of breastfeeding. The resolution of the 'legislation/enforceable requirements' remit and related perspective that UK social services are required to follow, and the actual needs of mothers from certain BME communities in regard to accustomed practice in the area of length of time/months-early years breastfeeding causes untold difficulties in the field of effective and professional/caring social services support and engagement.

Insensitivity around this topic continues to be a major source of disillusionment and direct family disruption and psychological harm for those BME mothers who in their breastfeeding practice fall foul of social service organisation 'expected norms of maternal practice.' Consequently two injurious results occur: some BME mothers avoid, out of a motivation of fear and distrust, any contact with social services support that would be highly appropriate and beneficial to their needs, and social services organisations staff who are not culturally aware step all too boldly and easily into actions that are of an incendiary character for race relations.

BME UK residents are also by default at the forefront in supporting the strengths and advantages of breastfeeding in regard to commercial [multinational businesses] vested interests that seek to oppose for self-interest reasons any breast feeding practice. In 'third world' countries multinational organisations have contributed in disastrous and deadly ways in marketing and lobbying for purchase of their 'alternatives to breast feeding' products. This has had a further negative impact on the credibility of UK social service organisations that through directives in effect support and enforce the marketing and promotion of big business multinationals that seek to maximise profit margins.

Links:
http://web.archive.org/web/20090316071541/http://www.4woman.gov/breastfeeding/index.cfm?page=227
http://en.wikipedia.org/wiki/Nestl%C3%A9_boycott

Post Natal Depression:

It is the common experience, in practice at actual real/community-society level that social service organisations following a predominantly 'legislation and organisation directive' approach at frontline service provision level, unwittingly become swiftly involved in perceived antagonistic and aggressive conduct in relating to many UK citizens who are BME. This reality has been highlighted in the details concerning breastfeeding.

Post natal depression is a universal phenomenon. The psychological impact of the process of childbirth affects all mothers, and the reasons for the related common experience of post natal depression are as self-evident as they are highly important. Social care in the UK embraces the topic, with various forms of support being available to mothers encountering post natal issues and needs.

Unfortunately, BME mothers, in comparison to others, commonly face insuperable challenges to receiving the level of care in this regard that non-BME mothers can access. For them not only in certain contexts for cultural reasons the negative perception of social service organisations in regard to breastfeeding occurs, but the broader and psychologically injurious impact of racism and discrimination impact too.

At this time little work has been done into research around this perennial and highly important matter, yet the phenomenon remains and with it being still ineffectually addressed. As a result, many BME young mothers suffer severe mental distress, and social service organisations remain at a practical service provision level ineffective in regard to the quality and level of support that they should be providing to BME service users, and members of BME communities that for reasons of accountable distrust, choose not to use social service support.

Link:
http://www.hindawi.com/journals/nrp/2012/181640/

6. BME women's needs and issues

Although far from exhaustive, the following details provide some highlights of the particular needs and issues faced by BME women in comparison to the general non-BME female population of the UK.

There are 2.3 million Black and Minority Ethnic women (BME) in the UK, representing 7.9% of the UK female population and 13% of the female population in England (Office of National Statistics, 2003). Unemployment rates are higher for women in every minority ethnic group than for white women. Source: http://www.equal-works.com/resources/contentfiles/5798.pdf

'The UKOSS survey (2009) showed that Severe Maternal Morbidity was more than twice as common among women of African (2.35 RR) and Caribbean (2.45 RR) origin …'

'Ethnic inequality exists in the reported use of screening for cervical cancer (Moser et al 2009), although South Asian and Black women above the age of 65 have a higher incidence of cervical cancer …'

'The infant mortality rate in England and Wales for children born to mothers from Pakistan is double the average …'

'There is a high incidence of dementia and depression among minority ethnic women over the age of 65 …'

'Some Chinese women have also reported difficulties in communicating with health professionals, because the latter may not have the same understanding of their illness. For example, many Chinese women would share the belief that dizziness is caused by 'wind' inside the body, and that a sore throat is due to excessive internal 'heat'. These concepts would be difficult for Western biomedical professionals to understand, let alone to accept (Chau and Yu, 2002, 2004).

'Women don't access services for fear of their children being taken away from them …'

'Women rarely confide their health or personal problems to men to avoid embarrassment 'shame.'

Cervical Screening:
A *YouGov* survey of 1,179 white women and 1,177 black and minority ethnic (BME) women, aged 20 to 65, found that just 65 per cent of BME women thought cervical screening was a necessary health test, compared with 73 per cent of white women.

More than two-fifths also said they wanted a more detailed explanation of the dangers of not attending screening, compared with 36 per cent of white women.

Just 49 per cent of BME women knew that the human papillomavirus (HPV) causes cervical cancer, compared with 60 per cent of white women.

Source: http://www.netdoctor.co.uk/interactive/news/theme_news_detail.php?id=800621820&tab_id=116

Perinatal mental health care for black and minority ethnic (BME) women:
The study, conducted between August 2009 and March 2010, used data from 45 completed questionnaires and in-depth qualitative interviews with a sample of 15 respondents. … More than half the respondents stated that they had no services specifically tailored to meet the needs of BME women. Service delivery for minority women tended to focus on language and translation. The article suggests that this might mean that the cultural and specific needs of some BME women remain unmet. The author notes that lack of research and service evaluation in this area means that the evidence base for the efficacy of BME-specific services versus culturally sensitive mainstream services is lacking.

Source: http://www.scie-socialcareonline.org.uk/profile.asp?guid=79b1a747-a16e-4d84-8c37-c38796016885

Regarding mental health challenges for South Asian Women:
This paper describes a survey carried out by a South Asian women's voluntary organisation to identify the physical and mental health needs of its users. The results confirm research findings that suggest a high proportion of South Asian women suffer from psychological and somatic symptoms that are commonly associated with anxiety and depression. A considerable number had experienced racial discrimination and several had suffered sexual discrimination. Problems reported by participants included eating disorders, marital difficulties and domestic violence. The majority did not know where to seek help for mental health problems. Respondents wanted confidential talking and complementary therapies to be provided in services run by South Asian staff, and for health education and health promotion to be provided in their own ethnic language.

Source: http://pierprofessional.metapress.com/content/850141m11667521m/

7. Needs of the elderly

The challenges faced by the Chinese elderly in particular stem from English language skills (that reinforce their restricted interaction with the broader population and public services interaction in particular). A further complication is caused by traditional culture related stigma concerning mental health issues – especially in the field of low mood / depression and anxiety. In addition, the UK Chinese elderly have decreasing confidence on being able to rely on support for their health and medical needs caused by aging, from the traditional Chinese family structure.

Second and third generation family members are increasingly Westernised, and faced with career and occupational priorities that diminish their ability in terms of time available to care for parents of retired age and older.

The options of care homes and visits by healthcare workers, are to elderly members of BME communities alien at best, and at worst intolerable contraventions of traditional family practice and values.

Example: Reasons for depression amongst the UK elderly Chinese community

A Bristol and Avon Chinese Women's Group (BACWG) mental health information pack highlighted the following findings (listed in order of importance):

1) Social and cultural isolation -- the importance of Family care (rather than external authorities), but pressures of Western society mean many younger generations adopt a more Western outlook about care for the elderly – a culture shock for the latter brought up differently.
2) Stress and Anxiety
3) Language
4) Physical Illness
5) Race Discrimination

‘There is a strong sense in the Chinese community that **self help**, early detection and greater awareness about mental health through information would help avoid the problems currently associated with mental illness for many individuals’ (Cowan 2001; Li & Logan 1999).

8. BME Carers and ‘Caring’

‘Carers from minority ethnic communities are rarely the focus of social work assessment and support’

‘Irish (2.5%), Bangladeshi (2.4%) and Pakistani (2.4%) groups had the highest rates of spending 50 hours a week or more caring according to the 2001 census figures,’ but many minority ethnic carers tend to care unaided and in isolation…’

As a result of continued traditional cultural values BME carers [of elderly, disabled and medical condition-related family members and friends] constitute at a collective level, the most consistently dedicated of UK population groups in the field of carer activity.

Lack of awareness of what support exists for caring activities is an issue that is being progressively addressed, yet there still remains in more traditional BME family settings a concern about strangers coming into the home environment, and that through receiving carers support control over their lives and those they care for can be compromised. As regards assistance with washing and dressing, it is commonly not culturally acceptable for a helper to do this, but for a nurse instead.

9. Domestic violence

Surviving Abuse: the BME woman’s perspective: Practice Development Seminar Report
Tuesday April 11th 2006.

‘Avdhuti shared her experience of domestic violence at the hands of her husband and in-laws. She spoke of the particular barriers she faced in accessing support: not knowing English, feeling isolated and having no one to turn to. Avdhuti’s parents told her to put up with the abuse as they felt she had no future without a husband. She also expressed that her family never seemed concerned about her happiness but were only concerned about the family’s reputation.’ **Avdhuti Parekh:** AWRC user

‘Jane stressed that it is important that women are supported in a reassuring environment where they are not judged. African women’s responses to violence and abusive behaviour may be influenced by the chronic experiences of racism and the social context in which they live. Some women may fear losing their rights to stay in this country if they leave their abusive partners.’ **Jane Lanyero:** African Women’s Care

Source: the *Asian Women's Resource Centre*: 108 Craven Park, Harlesden NW10 8QE

Barriers to help for BME women suffering from domestic violence:

Physical, sexual and psychological abuse is a phenomena that sadly exists for a minority of UK citizens irrespective of gender, ethnicity religious or cultural beliefs or sexual orientation. However, for those members of the BME female population that suffer from such forms of abuse, the barriers to accessing help and information are commonly greater than for non-BME women in such alarming and occasionally life-threatening situations.

Abuse of women within (or without) marriage has extensive and severe physical and mental health impacts, and in the case of such abuse, can be more difficult to challenge for BME women victims:
"The impact of violence on BME women may be worse than for other women . . . there are additional barriers to leaving their partners." … it [the report] estimates, for example, that the cost to society of violence against BME women is around £1.5bn.

Source: http://www.guardian.co.uk/society/2008/apr/23/equality

Though BME women are just as likely as others to be victims, there are differences in how they respond to violence and how they are treated by services.

Research has highlighted the specific issues in relation to BME women pointing to their 'double victimisation' – the violence perpetrated by partners and family members and then the failure of services to provide appropriate support and interventions (Gill, 2004:466; Rai and Thiara, 1997). The failure to protect by agencies such as the police and health professionals along with the neglect by family members reinforces and perpetuates violence in women's lives.

Reporting and help-seeking - issues of access

Research shows that women from BME groups are less likely to access existing services and that there is generally a low level of awareness of refuge support services among large numbers of BME women which leads them to endure abuse for longer periods

Religion and culture

Sensitivity to their religious and cultural practices has been shown to make a considerable difference to the quality of the experience that many BME women have and often dictates whether they stay or return to violence. The availability of a culturally specific service - with access to workers from similar backgrounds and which facilitate sharing of experiences with other BME women - can be crucial to a woman's recovery from DV.

Source (p2-3): http://www.cahrv.uni-osnabrueck.de/reddot/Ravi_Thiara.pdf

Example of work in this field:

Services in Poole have, in a number of cases tried to support women from BME communities to end domestic violence and worked with communities and faith leaders to support them. There are challenges for BME communities in accepting and supporting women who report domestic abuse.

It is best practice to use an independent interpreter and not a family member in cases where there are concerns of domestic abuse. Particularly in cases where there is a suspicion of 'honour' based violence or forced marriage.

The following recommendations are made for services employing interpreters:

- Ensure that staff brief and debrief interpreters prior to and following the session
- Provide the opportunity for interpreters to fully explain their role and duty of confidentiality
- Be aware throughout an interpreting session of any difficulties expressed by the service user
- Terminate the session if a service user indicates an interpreter is not suitable

- Avoid leaving service users and interpreters alone at any time before, during or after the session

● **Karma Nirvana:** supports victims and survivors of forced marriage and ‘honour’ based abuse. Contact number: 0800 5999247
● www.southallblacksisters.org.uk
● https://www.gov.uk/government/publications/three-steps-to-escaping-domestic-violence

Note from Poole Borough Council social services regarding its work in this area:
Borough of Poole commissions a range of domestic and sexual violence services which are required to provide services to all victims, male and female and from all equalities groups. There are cultural barriers in accessing services and reporting abuse to the Police which can limit the support that a victim is able to receive. The Bournemouth and Poole Domestic Abuse Strategy acknowledges the issues and has identified actions to help mitigate this. In addition, a briefing paper has been prepared helping front line staff to understand what options are available when supporting victims with no recourse to public funds.

10. BME communities Long term Medical Conditions, Health Trends and diet considerations:

‘Research in health and social care shows that many minority ethnic communities experience poorer health in comparison to the national population. Research also shows that there is great disparity in how they access health and social care services. The extent of health and social care inequalities varies from community to community and shows the need for focused support and work with each community. …’

‘Self-reported health problems like anxiety, respiratory problems like asthma and bronchitis and chest pain were twice to five times more prevalent among Gypsy Traveller communities

‘There is evidence of significant levels of ill-health due to trauma, isolation, immunity-related problems, sexual health, disability and undiagnosed issues among refugee and asylum seeker groups …’

‘The risk of cardiovascular and renal complications is greater in patients from South Asian backgrounds, with 50% higher mortality rate …’

‘People from minority ethnic communities are up to six times more likely to develop Diabetes …’

‘People of African and Caribbean origin are at increased risk of having a stroke, and the number of people affected by the condition is higher among this ethnic group than any other …’

‘South Asians have a higher incidence of liver cancer when compared to the general population. South Asian women have a higher risk of oral cancer. Black men and women have a higher risk of cancers of the stomach and liver, and black men have a higher risk of prostate cancer and are more likely to die younger from this. …’

‘Young people from BME groups show disproportionate experience of many of the known risk factors for developing mental health problems, including exclusion from school, being in care, involvement with the criminal justice system and homelessness…’

'Sight loss services are poorly prepared to meet the needs of people with visual impairments from minority ethnic groups, while community organisations in these groups do not know what services might be available to their members …'

Source: Afiya Trust -- *Achieving Equality in Social Care*

Type 2 Diabetes Mellitus:
A third of African and Caribbean adults and some children suffer from type 2 diabetes. The cause of type 2 diabetes is understood in the community and treatment is being sought. A proper diet and more knowledge about the risk factors for type 2 diabetes such as obesity, (which is prevalent in African-Caribbean communities) would help ensure that the incidence of diabetes does not increase further. Source: http://www.bmehf.org.uk/media/gpawfactcards/WSPM01Print.pdf

BME people with sight/vision loss:
It is likely that, due to a lack of awareness of the registration process and the benefits of registration, people from BME communities are underrepresented amongst those who register as blind or partially sighted. People of African-Caribbean descent are eight times more likely to develop glaucoma than the general population and it tends to appear 10-15 years earlier than in other ethnic groups.
Source (page 9): http://www.asksid.org.uk/bme/docs/BME_GoodPracticeGuideFinalVersion.pdf

Health experiences of Nepalese UK citizens:

The understanding about the health issues experienced by the Nepalese population (both UK citizens and transient populations such as Nepali international students) living in the UK is limited. A small number of studies have shown that chronic illness such as hypertension, diabetes and obesity among elderly and sexual health issues and alcohol/drugs issues among young population are the major problems in Nepalese residents in the UK. Likewise Chinese population, the health experiences and use of health services of Nepalese population depends on various factors such as social and cultural issues, traditional health beliefs, migration issues and settlement patterns. The lack of common language for communication particularly among most of the women and elderly Nepalese population and their dependency on their male family members is another barrier which restricts the majority of health professionals' to understand their health issues/problems. Moreover, lack of understanding the health system (NHS) restricts the access to GP and other health facilities. Sometimes, the long waiting time and complexity to understand the referral process adds up to their frustration to access the health services. The need is to create awareness among the Nepalese population about the available health services and empowering women and elderly to benefit from these services without depending on their male family members.

Health Experiences of Chinese UK Citizens:

'Many mainstream health professionals are unaware that Chinese people's health experiences and use of health services are affected by complex factors, including traditional health beliefs, settlement patterns and family roles. For example, many have regarded interpretation as a key measure to break down language barriers. However, negative experiences with interpretation services include unavailability of the service, not knowing of its existence, and poor quality of interpretation, resulting in inaccurate diagnoses and inadequate explanations of treatment (Mind, 2008).

'A survey on self-reported experiences of patients from black and minority ethnic groups (Healthcare Commission, 2008) notes that Chinese people are less likely than other groups to give positive responses to their experiences of health services, and seemed to find it more difficult to communicate effectively with health professionals.

Source: Race Equality Foundation paper *'Health experiences of Chinese people in the UK'*

Diet and food: some representative examples

Food and diet are especially important matters in defining core BME cultural identities and related religious and ethical core values. Awareness of the interconnection of food-diet and world cultures is increasingly demonstrated in the diversity of specialist grocery stores, and even high street national food retail chains, across the UK – Kosher, Halal and vegetarian foods being particular examples. With the United Kingdom having a BME population of approximately 20% (according to the 2011 National Census statistics), it is important for practical considerations as well as demonstrating cultural competence, that UK social services organisations should provide for such needs in food options for service users.

Some representative examples of BME communities diverse dietary requirements, including important non-cultural, medical related facts:

Vegetarianism: many world/BME cultures practice different forms of vegetarianism, ranging from veganism, to fish/seafood but no meats, to including or excluding dairy products such as eggs, cheese (Beancurd / 'Tofu' is a common substitute for these).

Cooking of vegetable dishes in bowls and saucepans that may not have been sterilised after meat dishes had also been prepared in them previously; same issue applying to use of kitchen utensils. Such matters are especially important for strict vegetarians (such as certain Buddhist traditions).

Diabetes: in comparison to the general population of the UK, diabetes is commonly greater in many BME communities: having diabetic-friendly food menu options available in council day centres, community centres and care facilities for the elderly or infirm, is therefore important to BME service users and demonstrates inclusive / cultural competence.

Dairy products and lactose intolerance: Commonly BME service users from East Asian communities, such as the Chinese, are lactose intolerant. This means that they can potentially experience medical complications to differing degrees of intensity if they are given dairy products to eat or drink. Social services catering should always include dairy products free options therefore.

In the case of certain types of medical drug preparations – including in use for managing mental illness related conditions – high concentrations of lactose can sometimes be found: it is important that these should not be proscribed to East Asian BME individuals, since the complications can be highly adverse.

Ital: Rastafarian food:
'Ital' is a term used by Rastas, derivated from "vital", who means a natural and sane way of life. One aspect of Ital is the Ital food: because the body is a temple, you should not eat unpure food. Also you must take care of your body, cause it is Jah creation.

Ital is generally a vegan diet, even if some Rastas eat fish. Some prohibit salt, some not. In all cases, Ital prohibits pork, preservatives, chemical ingredients. Ingredients have to be the most natural possible.

In Jamaica, Ital cooking is most often inspired from Indian and African cooking. But many recipes can be "Italized" if prepared only with vegetables and natural ingredients)

Source: http://afroeurope.blogspot.co.uk/2009/06/ital-food-eating-vegetarian-like-rasta.html

Fasting:

Fasting is an important spiritual aspect of many religions, such as Islam, Hinduism and Judaism, and indeed in Rastafarianism and some forms of Christianity. As well as the abstinence from food (and sometimes drink), fasting is also usually a time of prayer, reflection and purification. It is an opportunity for people to adapt to a healthier lifestyle by learning self-control and making changes to their diet.

Depending on the religion, fasting will last for different lengths of time. In Hinduism and Judaism there tend to be individual days of fasting. However, the Islamic month of Ramadan is one of the longest periods of fasting, when it is compulsory for all healthy Muslims to fast between the hours of sunrise and sunset.

Source: Diabetes UK. Diabetes Information: Reviewed March 2009
Link: http://www.diabetes.org.uk/upload/Languages/New/English/Fasting-Eng.pdf

OBESITY: The diet of African–Caribbean people is the main risk factor for obesity. It is not helpful that the consensus in African Caribbean communities is that being obese is part of being wealthy. Knowledge that obesity can lead to other health issues e.g. high blood pressure, heart problems, type 2 diabetes and high cholesterol is vital to the community.

Diet and medication: Incompatibilities of some types of food with the taking of prescribed medicines:

Warfarin negative reaction to pineapple and cranberry foodstuffs and drinks – link:
http://www.nhs.uk/conditions/Anticoagulants-warfarin-/Pages/Introduction.aspx

Bread and yeast intolerance: Link: http://www.allergy-details.com/yeast-allergy/yeast/
Example of a dish being bread free but the container it came in had been contaminated by bread in its preceding use.

Dairy products/lactose intolerance: Link: http://www.nhs.uk/conditions/Lactose-intolerance/Pages/Introduction.aspx Chinese / East Asian people commonly have a high degree of lactose intolerance: something that community centres and social service facilities need to be aware of in providing food and drink to East Asian service users.

11. Sexual Health

The following valuable introduction to the issues involved in this subject area detail has been provided by Dr Rajeeb Kumar Sah (Senior PhD Scholar at Canterbury Christchurch University

'The UK population comprises of people from multicultural, multiracial and multi-ethnic society with different languages, beliefs and practices. Increasing cultural and religious diversity in the UK has signified the need and importance to understand various social and cultural factors affecting the sexual health issues among BME population. BME population have often struggled to integrate and find themselves stranded between eastern and western culture, especially young children, they sometimes even cause conflict with parents as they are willing to adapt to the western freedom. Although strong family ties remains the core of the BME families, the intergenerational differences is quite visible while discussing about sexual health and related issues. The sexual health of BME population is often embedded within social structure and cultural beliefs and it is strongly affected by different social and cultural factors at individual, family, community and national levels. BME groups have been identified representing disproportionate burden of sexual ill-health in the UK. Despite the provision of sexual health education amongst BME communities, they are marginalised, socially excluded and are vulnerable to risks associated to sexual health. Ethnic variations, cultural factors and gender differences have shown strong influence on sexual health of BME population. It is reported that only a small number of Asians are engaging in sexual intercourse. This may be because of the fact that data about sexual activity is usually under-reported due to cultural expectations not to engage in pre-marital sex. It is also believed that Asian females are more conservative towards sex but it does not rule out the risk of sexual health issues among this population. The immediate need is to provide accurate information about the sexual health services available for the community and it would possibly safeguard them from the risks/vulnerability of sexual health and related issues.

Brook, young people's sexual health charity, provided various recommendations to support health professionals in engaging with BME young people with sexual health services. Some of them were:

- Promoting sexual health services and positive sexual health messages that should be accessible and inclusive to all rather than singling out any particular groups
- Ensuring that sexual health services are confidential
- Incorporating cultural and gender differences in sexual health promotion
- Educating parents and family members about the importance and need of discussion about sexual health with young children
- Promoting sexual health services and positive sexual health messages thorough social networking and mass media, using school platform
- Showing and highlighting the benefits of sexual health services

Young BME people: sexual Health and sexuality

Younger generation BME UK citizens are increasingly free of traditional taboos and judgemental perspectives concerning sexual health matters such as responses to prevention or management of STD's. Many older generation and less Westernised community members are however still considerably influenced by traditional conservative perspectives.

Some young people from BME communities have significant difficulties coming to terms with a sexual orientation which is 'at odds' with their faith or cultural background. Services must make themselves accessible to young people from a range of communities and understand the implications of their culture on their ability to be open or confident about their sexual orientation. More information on Black and Minority Ethnic [BME] Lesbian, Gay, Bisexual, Trans and Intersex issues awareness is provided in Section 13.'

12. Mental Health

BME Communities and Mental Well-Being

'When asked what would improve their mental well-being, people cited community-based activities of all kinds, from sports to social events, along with advice and improved access to health services. GPs are usually the first port of call for those with mental as well as physical health problems.

However, many participants in the study have difficulty communicating with their doctors, not just because of linguistic and cultural barriers, but also because of the time constraints set on individual patient consultations.

Consequently, deteriorating mental health often goes undetected until it has become severe and as a result, BME patients are over-represented in acute care but under-represented at the counselling or psychiatric therapy stage. In other words, their treatment tends to be via by medication rather than by "talking therapy". In addition, they may often be misdiagnosed at this stage and are not informed of the diagnosis that is applied to them.'

A number of recommendations were made in the *BME Communities and Mental Well-Being in KCW* project paper an excerpt from which is cited above. A particularly important recommendation being:

10. **Staff training should include cultural diversity** so that BME user voices are heard, understood and supported by the mental health care system. It is equally important that BME users and carers are involved in the planning and delivery of this training.

Source: BME Health Forum: http://www.bmehf.org.uk/projects/previous-projects/mental-health#

There is an over-representation of BME groups (42%) in mental health services compared with the overall population, particularly people from the African and Caribbean communities, Refugee men and Muslim women. BME groups account for 37% of the households in temporary accommodation accepted as vulnerable due to mental health.

Source: http://www.bmehf.org.uk/media/gpawfactcards/WSPM01Print.pdf

A Bristol and Avon Chinese Women's Group (BACWG) mental health information pack indicated that the following were common reasons for not seeking help with depression:

1) Language
2) Not aware of services
3) Not aware of signs and symptoms of depression
4) Believe that they can help themselves and don't want to bother other people

More information about the causes of depression in older generation Chinese citizens is included in the section below concerning the elderly. As noted in the guidance notes of Section 3, to varying extents, both amongst some of the BME elderly and newer BME UK citizens who have minimal experience of Western lifestyle and culture and who retain considerable traditional [non-Westernized] perspectives, it is not uncommon for mental health problems to be regarded as instances of karmic retribution or even demonic possession. In such instances, mental illness is regarded as a matter of shame and a fait-accompli that cannot nor even should be challenged through seeking supportive care and remedies available.

Such perspectives are becoming rarer and do not apply to the vast majority of [Westernized] BME UK citizens, yet it is important to be aware that they can and do still linger as influences upon the thinking regarding mental health in the particular two groups indicated.

The ‘wish to not make a fuss’ approach to depression and anxiety (commonly fuelled by the impact of racism and race-based discrimination in addition to day-to-day living, work and economic factors) remains a perhaps greater challenge for more BME people in seeking remedies that are available to them regarding mental health issues.

13. BME Lesbian, Gay, Bisexual and Trans [LGBT] community individuals

One Minority at a Time please!

BME LGBT’s face a double challenge place them in positions of especial vulnerability compared to heterosexual BME individuals. Consequently, it is most important to note that from the social services perspective, BME lesbian, gay, bisexual and trans individuals be understood as distinct groups with particular needs due to the levels of discrimination that they commonly experience from non-LGBT/heterosexual individuals within their given broader BME cultures. Please visit the **Naz Foundation** International’s website -- http://www.nfi.net – for more information about perspectives for South Asian gay men.

It is important to note that the source of homophobic and trans-phobic discrimination and homophobia and transphobia (often of very severe kinds: burning to death, decapitation, mutilation as a punishment for those who express manifestations of same-sex love in private) -- as in parts of Africa and the Middle East, where gay and lesbian individuals face the very real risk of death/murder) -- is almost universally derived from religious fundamentalist/extremist sources. These do not represent the totality of views about same-sex love or transgender identities in the broader historical contexts of world cultures.

Black and minority ethnic gay, lesbian and bisexual people are worryingly invisible in public life, a new report from *Stonewall* says, with little provision made or support available for their needs.

There are around 400,000 black and minority ethnic gay, lesbian and bisexual people in the UK yet the report, *One Minority at a Time*, has found they are often met with ignorance, discrimination and prejudice.

Some highlights of the Stonewall report:

‘I think that I can either be gay or I can be South Asian, or I can be a Hindu. The fact that I can be all three becomes very difficult for people to comprehend. There is very little proactive support or encouragement to actually acknowledge the diversity of identities that do exist within an individual.’ Seiki, 47

Many of the participants agreed that they had at some point felt marginalised and isolated by the general lack of recognition that black and minority ethnic lesbian, gay and bisexual people exist.

‘There is a perception ‘oh you are Indian, you can’t be gay’ or ‘you are black, you can’t be gay’ but there are blacks that are gay, there are Indians that are gay.’ Eric, 24

Often, participants felt that the lack of understanding from public service staff mirrored wider societal assumptions that black and minority ethnic people are not gay.

‘I think they just need to stop seeing people as one box at a time. When asking those monitoring questions, if you get a yes for one doesn’t mean you have to stop asking the others.’ Kevin, 40

3 Health and social care: Summary:

- Healthcare professionals appear inadequately trained on issues relating to sexual orientation and ethnicity and often assume that people from black and minority ethnic backgrounds are heterosexual
- The assumptions often deter those accessing healthcare from being open with doctors, nurses and other health workers and sometimes stops them from accessing healthcare at all
- Healthcare workers often fail to recognise or acknowledge the existence of same-sex couples
- The culturally appropriate services on offer do not always take sexual orientation or homophobic discrimination from people within their own communities into account

Experiences of homophobic discrimination from people within their own communities made some focus group participants feel wary of health and social care workers from black and minority ethnic backgrounds.

'I find that I try to avoid black doctors which is terrible but the homophobia you can see straight away. I have had comments where, for example, a doctor will say 'well, you know that's not right, I will pray for you.' and I just don't need that. If I have to go and see my GP I will avoid the black woman because I know that she is going to be much more judgemental about everything than the white doctor,'

Source: http://www.stonewall.org.uk/documents/one_minority_at_a_time_final.pdf

It may appear that social services provision rarely impacts upon BME LGBT's, yet in reality upon the basis of not only statistics (as noted in the details above) but extensive day to day living discriminatory experience of this substantial yet 'seldom heard / hard to reach' community, it is certain that social services have in reality regular contact with BME LGBT individuals in their work.

The principal challenge is to have an awareness that given Black and Minority Ethnic communities do contain a substantial LGBT element, and that commonplace assumptions that BME communities are exclusively heterosexual hinders access to and engagement with this particular marginalised and vulnerable, commonly overlooked population group.

Source:
www.nasuwt.org.uk/Whatsnew/NASUWTNews/Nationalnewsitems/BlackGayPeopleFaceDoubleDiscrimination

Older lesbian and gay members of some BME communities are particularly vulnerable to self-stigmatization, due to their sexual orientation or self-affirmed gender identity, when influenced by traditional taboos of homophobic/transphobic kinds. This challenge to good self-opinion is considerably reinforced if they work and socialise in traditional workplace environments (restaurants, etc) and social contexts of traditional [non-LGBT inclusive] kinds that have minimal connection to and with awareness of broader UK inclusive LGBT community perspectives and rights.

The mental health implications of being a less Westernized BME LGBT individual with minimal spoken English and interaction with broader non-BME LGBT society, in such contexts are as severe as they are self-evident.

APPENDICES

Appendix A: Dorset - Multicultural facts overview

2011 Census Key Statistics Release 2.1 of 11th December 2012

Ethnic Group:

Results from the 2011 Census on ethnic groupings show that the BME* population across Dorset County Council has increased since 2001, increasing the proportion of the population in the BME category from 3.2% in 2001 to 4.4% in 2011. Nationally this increase has been much greater, rising from 13% of the total population to 20% of the total, approximately 1 in 5. The table below shows the % total BME population for 2001 and 2011 broken down by a number of areas.

	2001		2011	
	White: British	Total BME*	White: English/Welsh/Scottish/Northern Irish/British	Total BME*
ENGLAND	87.0	13.0	79.8	20.0
Bournemouth UA	92.5	7.5	83.8	16.2
Poole UA	96.0	4.0	91.9	8.1
Dorset	**96.8**	**3.2**	**95.5**	**4.4**
Christchurch	96.8	3.2	95.1	4.8
East Dorset	97.2	2.8	96.2	3.8
North Dorset	96.6	3.4	94.7	5.3
Purbeck	96.6	3.4	96.2	3.7
West Dorset	96.7	3.3	95.7	4.2
Weymouth and Portland	96.6	3.4	94.9	5.1

Table notes: BME* is the abbreviation for the Black and Minority Ethnic Population as defined by the Race Relations (Amendment) Act 2000. Under this definition the Black and Minority Ethnic Population comprises all ethnic groups with the exception of the White British ethnic category of the White ethnic group.

The greatest change in BME population within the County area is in North Dorset, growing from 3.4% to 5.3% in 2011.

The table below shows detailed breakdown of ethnic grouping nationally and across the County. The highest proportion of BME population was from the 'White: Other White' category at 1.8% of the total. North Dorset and Weymouth and Portland had the highest % within this category at 2.4 and 2.0% respectively.

National Census information kindly provided by Wendy Allwood (Dorset Social Services) and colleagues at Dorset County Council.

Profile / overview of the ethnic (BME) communities of Dorset, Bournemouth and Poole:

The BME communities of Bournemouth, Dorset and Poole are diverse and numerous. Some include those which have long been a part of the broader general community (Indian, [Hong Kong] Chinese, Caribbean and African, Jewish, Middle-Eastern, Bengali and Nepali [including Gurkha], amongst others). Others are relatively newer, such as from the EU Accession countries (Polish Dorset residents in particular), Mandarin-speaking Chinese and others.

The highest concentration of BME communities is found in the unitary authority areas of Bournemouth and Poole (especially Bournemouth). Bournemouth is commonly acknowledged nationally as the location of the greatest concentration of language colleges/schools outside of London. The conurbation area of Bournemouth and Poole has mosques, synagogues, an Orthodox Church, and a number of BME communities schools (Chinese, Polish, Kurdish and others) that work to preserve their respective cultures and also to help with developing English language skills and related integration with general UK culture/society.

In terms of occupations and professions, BME Dorset residents range from GP's and internationally renowned academics and businesspeople (from directors of estates agencies, nursing homes to restaurant owners and shops) to bus drivers, hotel and leisure industry staff -- from managerial to receptionist and other levels -- and NHS trusts. There is a considerable percentage of BME employees in NHS trusts, but to date they have not been able to break through to higher levels in the NHS staff hierarchy. This issue continues to pose a substantial equality and inclusivity credibility gap challenge for NHS organisations, but it is hoped that meaningful change will be achieved in this area in 2013.

In addition, the Dorset Race Equality Council is one of the most effective and active of race equality councils in England; its outreach and support work running counter to the national trend that in recent years has witnessed a substantial reduction in the number of county area REC's. Further, there a number of BME led multicultural learning and multiracial voluntary organisations in the Dorset area (Unity-In-Vision, Oriental Culture Educational Society, and the UK-Nepal Friendship Society being examples in the Bournemouth and Poole area).

BME run businesses and organisations that provide services to and for BME permanent or short-term residents (especially international students) contribute substantially to the Dorset economy. In the 2011-2012 period it was for example estimated that in the Bournemouth area, international students contributed in different ways to an approximate £400 million pounds input to the local economy.

A considerable part of the success of Bournemouth as one of the UK's leading tourist destinations results from its multicultural, relaxed and welcoming character – a factor that is responsible for the very high concentration of language schools/colleges that it has developed in recent years.

At the same time it should be noted that in parts of Dorset there are amongst some sections of the population preconceived views that the county is not a multicultural or multiracial one, that BME individuals are few and that there issues are not therefore of relevance to the white middle class taxpayer and voter. Furthermore, the Gurkha community in the Blandford area in 2012 reported negative experiences of being made to feel unwelcome by minority elements of the mainstream population: this despite contributing income to the local economy, and ultimately playing an important part in defending the UK across the globe through their historic contribution to the British Army.

BME representation at executive and senior officer levels of public sector organisations -- such as NHS foundation trusts and the Clinical Commissioning Group for Dorset and Bournemouth and Poole -- is minimal (or even non-existent). This reality replicates national trends that highlight de facto restrictions/exclusivity and the existence of a 'glass ceiling' in terms of upward mobility in career development for BME people no matter how gifted, professional and hardworking. Indeed in some of these organisations there is no BME representation at all at the higher levels despite a substantial presence of BME employees at lower ones.

Similarly in terms of BME employees recognized for outstanding achievement at annual awards events of many public service organisations, the same picture of minimal or non-recognition, confirms such trends. The resulting negative impact on the morale of BME members of such organisations is self-evident: sentiments of feeling marginalized / little valued are amplified further by experiences of racism encountered by them and family members and friends in the broader community.

A 2012 Bournemouth University research project regarding racial abuse experience of post-graduate students noted that a 3rd of participants, out of a total sample size of approximately 150, had encountered verbal or physical racial abuse of varying degrees of intensity in their [off campus] experience of living in the community.

Appendix B: Concerning ongoing changes in the NHS structure, and the role of the NHS service users organisation, Healthwatch:

'With the dissolution of the old Primary Care Trust NHS structure and its replacement by General Practice orientated Clinical Commissioning Groups, the NHS will for some time be in a state of flux: Foundation [mostly hospital trusts] and university foundation trusts [that, in the case of Dorset, cover mental health and a number of community services] are not being replaced. Again, from the Dorset area perspective (which conforms to national trends) many of the former functions of the new CCG's, and related Commissioning Boards, that were formerly provided by PCT's will be delegated to local authorities. This poses both opportunities and challenges for social service organisations.

Moreover, at national, regional and local levels, the transference of Equality Service Delivery has not been assigned in any formal/mandatory way to the new CCG's: this means that work to support the particular NHS access and equitable treatment needs of BME NHS service users will be urgently required to be embedded in the CCG's and Commissioning Boards.

The NHS and social services, service users organisation Local Healthwatch will be providing an especially important role in the new UK medical and healthcare organisations. It should be noted that liaison and the development of direct and positive/dynamic interactive relations between Healthwatch and local authorities social services will be particularly beneficial in helping the latter to deliver to BME communities. It should be noted however that Healthwatch provides an independent voice for social services and NHS service users; and therefore by definition does not, nor can provide equality and diversity service provision that NHS CCG's and social services are required to provide.'

Appendix C: Notes for social services and NHS organisations executive officers

NICE An assessment of community engagement and community development approaches:
Public health guidance, PH9 - Issued: February 2008:
http://www.nice.org.uk/nicemedia/pdf/PH009Guidance.pdf

Page 5 of the document notes: 'A variety of approaches are used … Although these approaches have been in existence for several decades, many factors prevent them from being implemented effectively, including:

- the culture of statutory sector organisations
- the dominance of professional cultures and ideologies in imposing their own structures and solutions on communities …'

Importantly, regarding the two points above, the NICE document notes the importance of the difference of *community engagement* and *community development*: the imposition of public health and social services sectors corporate priorities inhibit effective engagement with their customers/service users, and most of all with seldom heard/hard to reach minorities.

Minority communities, especially BME ones, have especial awareness of 'tick box' exercises and are particularly when they are approached by representatives (senior/middle management/or community level administrative staff) of public sector NHS and social services organisations, to 'help with a survey/questionnaire or interview that has the aim of improving the services they receive and listening to and addressing the issues in service provision they experience.' The all too common experience of contributing [unremunerated] time and information to a questionnaire or survey-based interview [that the interviewer is remunerated for at a professional/salaried rate], and which results in no or very minimal change regarding reduction and removal of a quality of service that is commonly very inferior to that received by non-BME service users/the general [non-BME] public , continues to prove a major credibility challenge for NHS and social services organisations.

The challenge of removing public health and social services 'tick box culture' is therefore one that is crucial for creating meaningful and effective dialogue with marginalized and/or minority communities, such as in particular BME communities.

A 'nothing about me without me' baseline approach (compared with a 'tick box' commonly perceived one) is therefore the only reliable one that can deliver a 'contract of trust' between minority (especially BME) communities and health and social service providing organisations. For this to be effectively established the ‘glass ceiling’ of representation of minority/BME individuals at senior management and executive board levels of social services and NHS organisations, has to be broken. No less importantly, mechanisms need to be provided for clearly showing meaningful change in the quality of service provision to BME service users, when they have been consulted about and provided invaluable input to surveying and other engagement activities by social services and NHS organisations.

Appendix D: Useful Links

Achieving Equality in Health Care: http://www.afiya-trust.org/images/files/Achieving%20equality%20in%20health%20and%20social%20care.pdf

Living in the Margins: www.livinginthemargins.org

A good practice guide: http://www.asksid.org.uk/bme/docs/BME_GoodPracticeGuideFinalVersion.pdf

Equal Works: http://www.equal-works.com/resources/contentfiles/5798.pdf

One in five local authorities failing BME communities by ignoring equality legislation:
http://www.carersuk.org/newsroom/item/2490-one-in-five-local-authorities-failing-bme-communities-by-ignoring-equality-legislation-claims-new-campaign-by-health-charity

Black & Minority Ethnic (BME) Communities - Housing & Social Care Strategy:
http://www.milton-keynes.gov.uk/housing-strategy/documents/BME_Housing_and_Social_Care_Strategy_%28adopted_by_Cabinet_06_02_07%29.pdf

BME Health Forum: http://www.bmehf.org.uk/projects/previous-projects/mental-health#

NICE An assessment of community engagement and community development approaches:
Public health guidance, PH9 - Issued: February 2008:
http://www.nice.org.uk/nicemedia/pdf/PH009Guidance.pdf (please see Appendix C below)

A Study of the Housing Requirements of Black and Minority Ethnic (BME) Households in Dorset and Poole: Executive Summary – 2010: http://www.dorsetforyou.com/media.jsp?mediaid=155340&filetype=pdf

Afruca: [Africans Unite Against Child Abuse]: Charitable organization promoting the rights and welfare of African Children in the UK:
http://www.afruca.org

Victoria Climbie Foundation: Organisation that campaigns for improvements in child protection policies and practices and to ensure effective links & coordination between statutory agencies, care services and BME communities:
http://vcf-uk.org

Breastfeeding:

http://web.archive.org/web/20090316071541/http://www.4woman.gov/breastfeeding/index.cfm?page=227

As a mother, one of the best things that only you can do for your baby is to breastfeed. Breastfeeding is more than a lifestyle choice — it is an important health choice. Any amount of time that you can do it will help both you and your baby. While breastfeeding isn't the only option for feeding your baby, every mother has the potential to succeed and make it a wonderful experience. Dive into our resources to find out how breastfeeding can be one of the most important things you do for both you and your baby!

Featured Article

Mothers and Children Benefit from Breastfeeding (PDF file, 40Kb)

By Rear Admiral Steven K. Galson, Acting US Surgeon General

In the News

- FDA Issues Health Information Advisory on Infant Formula
- Why Women Stop Breastfeeding
- FDA Approves 2008-2009 Flu Vaccines
- Health Tip: Why Baby Won't Breast-Feed
- Undoing the 'Big Baby' Trend
- Health Tip: Dealing With Depression After Pregnancy

http://en.wikipedia.org/wiki/Nestl%C3%A9_boycott

Nestlé boycott

From Wikipedia, the free encyclopedia

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A boycott was launched in the United States on July 7, 1977, against the Swiss-based Nestlé corporation. It spread in the United States, and expanded into Europe in the early 1980s. It was prompted by concern about Nestle's "aggressive marketing" of breast milk substitutes (infant formula), particularly in less economically developed countries (LEDCs), which campaigners claim contributes to the unnecessary suffering and deaths of babies, largely among the poor.[1] Among the campaigners, Professor Derek Jelliffe and his wife Patrice, who contributed to establish the World Alliance for Breastfeeding Action (WABA), were particularly instrumental in helping to coordinate the boycott and giving it ample visibility worldwide.

Groups such as the International Baby Food Action Network (IBFAN) and Save the Children claim that the promotion of infant formula over breastfeeding has led to health problems and deaths among infants in less economically developed countries.[2][3] There are four problems that can arise when poor mothers in developing countries switch to formula:

- Formula must normally be mixed with water, which is often contaminated in poor countries, leading to disease in vulnerable infants.[4] Because of the low literacy rates in developing nations, many mothers are not aware of the sanitation methods needed in the preparation of bottles. Even mothers able to read in their native tongue may be unable to read the language in which sterilization directions are written.
- Although some mothers can understand the sanitation standards required, they often do not have the means to perform them: fuel to boil water, electric (or other reliable) light to enable sterilisation at night. UNICEF estimates that a formula-fed child living in disease-

ridden and unhygienic conditions is between 6 and 25 times more likely to die of diarrhea and four times more likely to die of pneumonia than a breastfed child.[5]

- Many poor mothers use less formula powder than is necessary, in order to make a container of formula last longer. As a result, some infants receive inadequate nutrition from weak solutions of formula.[6]
- Breast milk has many natural benefits lacking in formula. Nutrients and antibodies are passed to the baby while hormones are released into the mother's body.[7] Breastfed babies are protected, in varying degrees, from a number of illnesses, including diarrhea, bacterial meningitis, gastroenteritis, ear infection, and respiratory infection.[8][9][10] Breast milk contains the right amount of the nutrients essential for neuronal (brain and nerve) development.[11] The bond between baby and mother can be strengthened during breastfeeding.[9] Frequent and exclusive breastfeeding can also delay the return of fertility, which can help women in developing countries to space their births.[12] The World Health Organization recommends that, in the majority of cases, babies should be exclusively breast fed for the first six months.[13]

Advocacy groups and charities have accused Nestlé of unethical methods of promoting infant formula over breast milk to poor mothers in developing countries.[14][15] For example, IBFAN claim that Nestlé distributes free formula samples to hospitals and maternity wards; after leaving the hospital, the formula is no longer free, but because the supplementation has interfered with lactation, the family must continue to buy the formula. IBFAN also allege that Nestlé uses "humanitarian aid" to create markets, does not label its products in a language appropriate to the countries where they are sold, and offers gifts and sponsorship to influence health workers to promote its products.[16] Nestlé denies these allegations.[17]