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WORKING TOWARDS HEALTH FOR ALL

COMMUNITY HEALTH COUNCILS, THE NHS AND OUR MULTI-CULTURAL COMMUNITY

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WORKING TOWARDS HEALTH FOR ALL: CHCS, THE NHS AND OUR MULTI-CULTURAL COMMUNITY

Report of a seminar held by the Association of Community Health Councils for England and Wales at the Royal Institute of British Architects on May 22nd 1990

INTRODUCTION

ACHCEW has been taking an active interest in the health needs of people from black and minority ethnic communities for several years and has been seeking to ensure that the needs of black and minority ethnic people are addressed by all Community Health Councils (CHCs).

A series of working papers for CHCs has been produced looking at: ways in which CHCs can seek to reflect more appropriately in their membership the interests and needs of local black and minority ethnic groups; how CHCs can improve their networking and liaison with local black and minority ethnic groups; and how CHCs can challenge racism in clients*. In addition it was agreed that a seminar should be organised,primarily for CHCs, but also for other interested organisations, to look at the issues in more detail.

This seminar was held on 22 May 1990 and represented the latest in a series of steps towards ensuring that CHCs fulfill their responsibilities in representing the interests of the local multi-cultural community. The seminar aimed to look at ways in which CHCs, and the National Health Service itself, can work to ensure that the health needs of black and minority ethnic people are met and that service provision is accessible and appropriate.

The day was organised as a combination of plenary sessions with key speakers and smaller participatory workshops. The workshops fell broadly into two categories: those which looked at ways in which CHCs can make themselves more race aware and sensitive and take positive action; and those which addressed the issue of health service provision, identified the areas where improvements can be made and suggested ways in which this can be tackled. This report is intended to indicate the main issues raised by the speakers and to highlight the types of concerns and ideas expressed during the workshop sessions.

Participants were primarily members and staff of CHCs, although there were a few delegates from health authorities, Family Practitioner Committees and voluntary organisations. Participants came from a wide variety of backgrounds, with varying expectations and experiences. However, the level of interest in the seminar in terms of low attendance was somewhat disappointing. This in itself indicates how much work needs to be undertaken to ensure that all CHCs see this issue as an integral part of their work and responsibilities, regardless of the composition of minority ethnic communities in their district.

It was made clear at the seminar that both the NHS and CHCs have a long way to go before the needs of the multi-cultural community will be met with any degree of adequacy. David Divine highlighted the lessons that can be learnt from developments in social services training. Shushila Patel pointed to the ways in which providers in the form of District Health Authorities can improve their services and how Community Health Councils can play an important role in this. Veena Bahl gave examples of how the Department of Health is tackling the need to develop good policy and practice on providing appropriate health services within the context of the NHS review.

The workshops reviewed the inadequacies in the current state of services for people from minority ethnic communities and went forward to make positive suggestions as to how the NHS and CHCs can be more responsive and sensitive to multi-cultural health needs.

Some of the key points made during the day which stress the tasks ahead for CHCs and service providers are summarised opposite.

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* "Appointments of CHC members", December 1988
"Networking with black and ethnic minority groups", March 1989
"Dealing with racist clients", October 1989

All available from ACHCEW, 30 Drayton Park, London N5 1PB

KEY POINTS TO CONSIDER

Health service providers need:

* Equal opportunities policies and strategies for: employment: recruiting staff, training, development service delivery
* Strategies to be monitored and reviewed
* High level commitment to strategy, coupled with ownership by staff
* Information on local population and health needs
* Adequate resources
* Consultation with local community on service planning and delivery and feedback on quality of services

Community Health Councils need:

* Equal opportunities policy and strategy, which is subject to regular monitoring and review, and in this context need to look at the work and membership of CHC
* Training to understand and meet cultural needs
* Information on local population and its health needs
* Good contacts and consultation with local groups
* Adequate resources
* Appropriate publicity about work and role of CHC
* To monitor local health services and encourage providers to meet cultural needs
* Ethnic monitoring of complaints

CONFERENCE REPORT

Cllr Hywel Wyn Jones (Chairman of ACHCEW) introduced the conference.

ACHCEW has for some time been actively concerned with the issue of health within our multi-cultural communities. A series of working papers have been produced on the practical ways in which CHCs can identify areas in which they can improve the service they provide for black and minority ethnic groups.

Both CHCs and the NHS itself have a responsibility to ensure that they provide services that are responsive to the needs of a multi-cultural community, and ACHCEW as an organisation decided that a seminar of this kind would be a valuable step towards developing greater awareness, greater understanding by CHCs and other organisations of the issues involved, and towards taking more positive action to start tackling the problems in this area which both CHCs and Health Service providers are facing.

FIRST PLENARY SESSION: David Divine - Assistant Director of the Central Council for Education and Training in Social Work.

"Acknowledging Difference"

The title of the talk today is "Acknowledging Difference" but the history of the provision of services to so called "Black and ethnic minority people" by service providers is one in fact of not acknowledging difference. A lack of acknowledgment of difference has led to various difficulties within the Social Services, and which are rather belatedly being tackled. I want to illustrate some of the major developments in the last year or two that are beckoning a much brighter dawn for the services to black and ethnic minority communities. There are a number of parallels here between health provision and social service provision. Health provision might well be now at a point where social services was some considerable time ago. Different services develop at different stages, for a variety of fairly clear structural reasons.

Twelve years ago it was possible in Social Work for you to qualify and enter into the profession, delivering services, and have no preparation whatsoever for the multi-racial reality of Britain today. Indeed, a major piece of research by Husband and Baker in the late 1970s surveyed over 67% of all qualifying courses, the vast majority of which did not consider knowledge of the histories, aspirations, needs, experiences, lifestyles and values of differing sections of the black community in Britain to be important enough to be a compulsory part of the course. This was reflected in service delivery throughout the 1980s, when service providers had a view that there was a "colour blind approach" to service provision. They felt that they were providing reasonable services to all, and one had to like their services or lump it.

We are not talking here about "goodies and baddies" when it comes to service providers, but about states of knowledge and thinking; how organisations function on a routine basis. There was a genuine desire to provide good services, but there was a minimal knowledge of the individuals that the service providers were attempting to service. In the White Paper, and the National Health Service and Community Care Bill, there is constant reference to the importance of the individual and the consumer. This is a quantum leap from practice in the late seventies and early eighties when the theory was there, but in terms of practice it certainly was not.

An important series of investigations by the Social Service Inspectorate during the 1980s found that in the vast majority of the departments they investigated, there was minimal policy regarding service provision to black and ethnic minority communities. Secondly, there was minimal participation by the local constituents in consultation about the level and relevance of service being provided. There was minimal senior manager knowledge about the individual communities. The organisations though they were providing a decent service, but never took the effort to check that out.

Firstly, they recommended that there should be a committee at member level, which oversees the implementation on an authority wide basis of policies aimed at achieving equality in terms of employment service provision. Secondly, the ultimate responsibility for advice and guidance on issues relating to black and ethnic minority communities must be located at a very senior level in the authority. All staff in the organisation must be involved in the development of any policy that you are attempting to implement. The research also stated that local authorities must undertake detailed demographic investigations about the populations they serve. Ethnic monitoring of staff was widely regarded as a necessary tool for promoting equality of opportunity in employment and career development and ethnic monitoring of service users was supported as a necessary part of the process of developing accessible and acceptable services for the whole community.

In 1988 the Association of Metropolitan Authorities (AMA) surveyed its members about implementing equalities policies. In short, they endorsed the SSI reports in saying that without policital and senior officer backing for any policy it is doomed to failure. Moreover, the level of resources allocated to the pursuit of equalities objectives, particularly the appointment of staff and staff development is absolutely crucial. There were major concerns raised by the member authorities about whether to focus on attitudinal change or work practices. They also reported monumental difficulty in implementing monitoring procedures in respect of the policy. In short, there were equality policies by the score, but there was still a significant deficit in practice.

Why was there a change in the eighties, to add to our agendas

various equality policies? We had a significant input by individual black professionals and black communities up and down the country. This was partly through the election in the early eighties of significant numbers of black councillors. The role of individual black voluntary organisations, particularly the black church, was also important in the early eighties. There was support from informed white politicians and professionals and white members of the lay communities, but essentially the driving force was very much centred around black individuals.

The significant display of unrest by primarily black youths in the early 1980s concentrated the minds of local and national politicians regarding the perceived deficit in service to a significant section of the UK population which had previously been ignored. Those few blacks who were getting into the system were increasingly alarmed that it was geared to keeping them out and designed to prevent decent services being provided to their own communities of origin.

The education and training of social services staff has altered, particularly in the last two years. It is no use simply asking people to pay attention to the significant numbers of black and ethnic minority people who are being serviced by us all, because we need to check out first of all whether the individuals we're talking to actually have the knowledge, base and order to provide a reasonable service. What training have they had? What level of resources are available to them for actually amassing this information? Within social work, we cannot allow this lack of acknowledgment of difference to prevail. We have accepted that as a profession we have failed, and we are also saying that there were circumstances which aided that failure which we are now beginning to address. If we do not make it mandatory, we are not going to have individuals who come out of training with the necessary knowledge that will provide decent, accessible and relevant services.

To address this, we have created a new qualification for Social Workers called the Diploma in Social Work, which will replace all existing qualifying qualifications in Social Work, and will affect all qualifications from 1994-5. We have included in the qualification a number of key areas (knowledge, skills and values), which prospective staff members are going to have to be seen to be competent in, before actually getting their certificate. These include a knowledge of: transcultural factors which effect clients needs in social work practice; social, family and community structures, processes of structural oppression, race, class, and gender and the notion of ethnocentricity; social welfare, theories of welfare, comparative social policies, the relevance of social security, housing, employment, penal policy, equal opportunities and race relations to the delivery of Social Services; the implications of political, economic, racial, social and cultural factors upon service delivery, the financing of services and resource analysis. They must repudiate all forms of negative discrimination and must understand and counteract the impact of

stigma and discrimination on grounds of poverty, age, disability and sectarianism. They must demonstrate an awareness of both individual and institutional racism, and ways to combat both through anti-racist practice. They must analyse and evaluate their own - and others - personal experience.

Before, in social work, it was an optional extra to learn about the needs of black and ethnic minority communities. Now, we are trying to translate statements of intent into practical, achieveable objectives which can be evaluated and monitored.

Finally, we should look at some of the effects of acknowledging difference. A major concern is that we have individuals who want to provide a service, but who have great difficulty in translating their knowledge into appropriate and relevant service provision. We are currently producing detailed guidance for local authorities, individual practitioners, and local colleges providing social work courses to help them guide their staff through this tricky maze. It is important that we don't condemn individuals for trying, and that we enable them.

In conclusion, we know now that the rhetoric is here to stay. We have considerable difficulties, however, in translating the intent into practice and this depends on at least three things. There must be political commitment both national and local; there must be resources ploughed in; and there must be significant, top level management commitment to the process, with the entire staff owning the various policies. We need to have a detailed look at the lessons learned by some of the organisations within the health field which are currently attempting to address the issues and to build on those. We all need to learn together within a climate which is non-condemnatory, and that is a very difficult climate to create. This is because of the pent up anger and frustrations of a significant number of our customers, and of black and white staff who have been attempting to address the issue, and been prevented by one means or another by the authorities that they actually work within. So we have got to contain and work with that anger, and at the same time make it an enabling process, because ultimately the benefits will be for all sections of the community, not simply the black communities.

SECOND PLENARY SESSION: Shushila Patel - District Equal Opportunities Officer for Tower Hamlets Health Authority.

How the NHS and CHCs in particular can promote responsive health services for black and minority ethnic groups".

I am going to talk briefly about the National Association of Health Authorities (NAHA) Project on promoting health services for black and minority ethnic groups. Secondly, I would like to highlight the issues raised from the report, including what is wrong with present health services. Finally, I will suggest recommendations towards a cohesive strategy in the National Health Services by highlighting the particular role of the CHC.

NAHA's project was initiated following a motion moved at one of its AGMs, stating that in any future report on collaboration, planning or delivery of services, NAHA should address specifically the requirements of the multi-cultural population, and should actively promote publications of good practice, to increase sensitivity and awareness of ethnic minority requirements. Consequently, NAHA sought and received financial support from the Department of Health, and established a National Working Party. The result was the report "Action Not Words", launched by the Minister at the time, David Mellor.

The report divided into three sections. The first highlights what is wrong with present health services. The second develops the role of each of the National Health Service agencies, working towards a coordinated approach. The third provides a model of guiding principles for District Health Authorities to adapt in promoting health services.

It is important to consider the historical pattern over the last thirty years on the wider issues of health and race. In the 1950s and 1960s, we saw an increase in the number of black and minority ethnic groups coming to this country; they were encouraged and invited to fill in the gaps in the labour market at the time. The general response from the indigenous white population and institutions was rather negative, and in extreme cases negative stereotypes were developed, which still persist today. During the Sixties and Seventies, the issue of health and race was emerging via social research studies, but the underlying assumption was that the problem was with the ethnic minority people; that they had different dietary, language and specific cultural needs which made it difficult for them to fit in and that once they started to integrate within the wider community by learning the language, learning to eat fish and chips and so on they would be alright. In the Eighties, there was a general progression in people's knowledge and awareness about the inadequacies and the inequalities that exist. At least some management members are beginning to acknowledge that it is their problem for not meeting the needs of the black and ethnic minority groups. I am saying acknowledging, not necessarily committed to work towards eliminating it, and I think that is an important point.

At the same time, black and ethnic minority groups and individuals themselves are no longer passive recipients of the health service, which for too long has been inadequate, inaccessible, inappropriate and even offensive. A lot of the initiatives taken in the health field have been by black and minority ethnic groups and individuals who are working very hard, both in a voluntary capacity and within the NHS.

One problem with the present health service is the extent of racial discrimination which exists both in employment and in service provision. Access to the service can be made difficult by restricted opportunities or reliance on provision which itself is inappropriate, insensitive and in some cases non-existent. People from ethnic minority backgrounds may be talked down to, intimidated and be victims of negative racial stereotypes when in contact with NHS staff. We have considerable evidence of areas where ethnic minority people are directly or indirectly discriminated against in the health service. If you look at the level of patient reception handling, black and ethnic minority people are often kept waiting unnecessarily and experienced staff make racist comments within hearing distance of the patient. For example, two receptionists, talking amongst themselves - the first one says to the second "They should all learn to speak English, shouldn't they, instead of wasting our time", and there are black people sitting close by. The second one then says "Well I know a few of them don't, but the more intelligent ones do, don't they?".

This patronising attitude obviously has an impact on black and ethnic minority groups using services. During clinical consultation, professionals often give very limited, poor or no explanation to ethnic minority people about their health issues. Assumptions are made that they are faking an illness, or are simply hypochondriacs. An example brought to me involved an elderly Asian patient who was diagnosed as having diabetes by his GP. The GP gave him an injection to increase his sugar level, but did not explain to him the course of diet he had to take together with his injections. So when the community nurse came to visit him, he had excess sugar in his blood, and she became very irritated by his repeated pattern of having excess sugar. Instead of finding out why the situation kept on recurring, she very derogatively looked at this patient and said "You've been very naughty, haven't you? You have not been listening to me". It was not until the man had made contact with one of the ethnic minority organisation's community worker, that his confusion around his health was finally resolved.

Our initial NAHA survey in 1987 showed very limited evidence that the provision for black and ethnic minority people is routinely integrated into all training, planning and delivery of services in health authorities. Very few health authorities have funded projects or initiatives to improve services for ethnic minority people from their mainstream budget and most are still relying on soft monies, such as Inner City Partnership funds. We need resources and commitment from health authorities to ensure that

the needs of ethnic minorities become part of the mainstream funding allocation.

Very few black and ethnic minority people are involved in health authorities' main policy making or have a say in the planning of services. Very few senior officers in health authorities have formal responsibilities to develop and enhance services for ethnic minority people. Much energy, anger and time is committed by black and ethnic minority people to see what they want, but when it reaches people in senior positions, because it is not part of their performance duty, they are not going to take it on board.

There is also very limited medical research on service provision or health issues which are of particular concern, or prevalent to, black and minority ethnic groups, for example, hypertension, heart disease, diabetes, genetically determined conditions such as sickle cell anaemia and thalassaemia. This is going to be of particular concern in light of the NHS review proposals and the role of District Health Authorities.

The Department of Health has a key role to play in ensuring that proper provision of all health care needs of black and ethnic minority people is achieved. The Department has taken a number of initiatives, such as the Asian Mother and Baby Campaign, and projects like the King's Fund Task Force on Unemployment, the National Association of Health Authorities Project. As a response to a recommendation in the NAHA report, David Mellor stated in the House of Commons that they had begun to integrate ethnic minority health into the review process and that henceforth it would be a standard feature.

Guidance has been sent to DHAs and Regions to ensure that the needs of black and ethnic minority groups are taken full cogniscence of. The Health Service Development Resource and Planning Guideline Circular states that Ministers expect health authorities to identify the health care needs of their population, taking account of the particular needs of ethnic minority groups, and ensure that these needs are met by a comprehensive range of services which make the best possible use of the resources available. Although this is quite encouraging, I have gathered that not all senior officers working towards the NHS review are fully aware of the implication of this Circular, or are making the best use of it. Many have decided to ignore the Circular's particular recommendation with reference to ethnic minority people, whilst others have not got access to this Circular. I am not aware if all CHCs are aware of the Circular and its implication, and if so, are they making full use of it?

Regional Health Authorities will have to ensure that all specific health needs of our multi-cultural community are met by identifying services specific to black and ethnic minority people, for example, adequate provision for sickle cell anaemia and thalassaemia.

The purchasing role of DHAs has to be welcomed with a degree of optimism. They will be expected to identify and purchase the services needed by the people who live in their districts, including the local ethnic minority community. Districts will be required in need assessment to collect data routinely by incorporating race, religion and first language spoken for the local population. They will have to develop comprehensive epidemiological assessment and monitoring of the health stages of the whole population. The introduction of the contractural process is perhaps an opportunity to address equal opportunities, for example by establishing well defined criteria for the implication of equal opportunities issues as an integral part of minimum standard specifications in the contracts. DHAs will need to develop a community advocacy role, using their combined power to ensure that priority is given to consumer needs. I feel it is absolutely crucial that the role of the CHC is enhanced to work together with the District Health Authority on this community advocacy role.

CHCs need to ensure that appropriate measures are taken to identify local community needs. This might be by organising appropriate conferences, seminars, local consumer surveys, developing adequate quality assurance schemes and promoting complaints procedures. CHCs could develop consultation forums for local ethnic minority people , and the future District Purchaser Unit.

What are CHCs doing to empower local black and ethnic minority people, such that they can effectively articulate their needs and contribute to health authorities' planning procedures? What efforts have CHCs made to publicise and promote their own services to local ethnic minority people? You might find this surprising, but there are towns in Britain where the local ethnic minority people, or people generally, do not have a clue where they can find their CHC. How is the local population informed of the implications of the NHS review locally, such as proposals for self-governing status and the DHA's purchaser/provider role? What actions are taken to empower local ethnic minority community care organisations and individuals to develop their services such that they can tender for contracts under the new system, such as catering services?

Before Community Health Councils can perform any of these however, I feel that they need to ask questions about their own performance: does the CHC itself have an equal opportunities policy with a proper recruitment and selection strategy, and is it being implemented in the truest sense; does the CHC adequately represent the local black and ethnic minority people in its membership and work plan; if not, what mechanisms have they pursued to ensure that they are keeping these issues alive at all times? It is no good relying on a tokenistic one or two ethnic minority people, like predominantly male religious leaders, who are not likely to give the true community view.

THIRD PLENARY SESSION: Veena Bahl - Principal Officer and Adviser on Ethnic Minority Health in the Department of Health.

Thank you for giving me the opportunity to learn what is happening at grass roots on ethnic minority issues and take back to the Department the valuable views people express at this conference.

I am going to trace some of the attitudes towards ethnic minority health by District Health Authorities and Community Health Councils, and look at what action the Department of Health has taken recently to see that the needs of black and ethnic minorities can be incorporated into planning and implementation of policy in the National Health Service. I would also like to make some suggestions to CHCs on how they can include black and ethnic minority health in their work.

CHCs' role needs to be seen in conjunction with health authorities. The first question to ask is whether health authorities have dealt with the issue of ethnic minorities, race and health policies. The simple answer is that the NHS is only beginning to be aware that black and ethnic minorities have differing needs, and that these groups are even present in their population. My experience in working with DHAs and CHCs mainly comes from running two campaigns, the National Stop Rickets Campaign and the Asian Mother and Baby Campaign, and more recently work on policy development which has brought me in contact with the district health authorities, CHCs and Family Practitioner Committees. During the Asian Mother and Baby Campaign, I met planners and policy makers from different health authorities and I asked some health authorities which ethnic minorities resided in their population. The answer was, "We may have some Sikhs, or we may have some Punjabis, and we have some of those people from Afro Carribean communities who are vegans, I think they are called Rastas". I asked one DHA, with a very large ethnic minority population, what plans and policies they had to meet the needs of the ethnic minority community locally ane their response was, "Well, we have some ethnic minorities, but they are mainly middle class and they do not need services because they look after their own. We do not want to force services down their throats, they are O.K."

During the campaign I looked for colleagues in senior positions in the health authorities who would help me and support the issue of ethnic minority health. I am afraid I did not find a single ethnic minority person in a senior position in the health authority. There were certainly some in the middle management level.

As far as the community consultation was concerned, I asked an FPC at a review meeting, "How do you consult the community?" and the response was "We have a very nice man called Mr Patel on our FPC, and he knows all about ethnic minority communities, and I am sure he can supply us the information that we need." I also turned to CHCs for help during the campaign. Some CHCs have

addressed the issue well, but there were others who were going to deal with the issue and some had not thought about this subject. For example, not many CHCs were aware that there is a very high rate of infant mortality among the Asian community, that coronary heart disease, diabetes and admissions to mental hospitals are high among ethnic minority communities. Many CHCs do not have the local ethnic minority population breakdown or have access to health and disease patterns of the ethnic minority communities.

However, in the past it has not been easy to get this kind of information. The 1981 census only recorded people from their country of origin and did not take account of ethnic minorities that are born in this country. Population information was always, and still is, very patchy. Some CHCs did not have a general idea of the ethnic breakdown of the population. They indicated, "We have Asians, Africans and Caribbeans in our population." When planning the health services, it is important that both the health authorities and CHCs recognise that these groups now are not homogenous groups, and there are many smaller groups within the Asian and Caribbean and African communities.

Let us now look at what is happening at the present time in the National Health Service. Some health authorities and CHCs have tried to improve their record on ethnic minority health and have attempted to bring ethnic minority health into the mainstream planning of the authorities. The Department of Health has also played its part in promoting equal opportunities in employment and service delivery. Firstly, there was the Asian Mother and Baby Campaign. By appointing link workers in health authorities, the campaign highlighted how bad service delivery to ethnic minority groups was, and also that black and ethnic minorities need to work in the Health Service at all levels to be able to influence policy and implementation. Black and ethnic minorities tend to be appointed in lower grades in Health Service and we need to change this situation and see more senior managers and policy-makers who come from black and ethnic minority groups.

Over the last three years, the Department has started reviewing RHAs and FPCs on their performance and has highlighted the need to incorporate ethnic minority health in these reviews. Some reviews highlighted how poor some senior planners were in recognising issues surrounding the health of ethnic minorities. The positive result of reviews was that we saw changes, for example, North East and North West Thames RHAs have appointed a consultant to coordinate policy on ethnic minority health at the region. I understand Bradford Health Authority has also appointed a senior person at the region to coordinate policy on ethnic minority health. There are a number of districts where equal opportunity posts are being created.

Recent discussions on the White Paper, "Working For Patients" have highlighted the concerns of ethnic minority communities about how the new structure is going to affect them. The Department is looking at ways to incorporate ethnic minority health in the development of the White Paper proprosals.

The recent steps by the Department to improve planning and policy development on ethnic minorities are firstly, the Department has taken a positive step to include ethnic minority health in the planning guidelines, to encourage authorities to plan for their local ethnic minority population.

Secondly, the Department is considering the introduction of ethnicity into the Korner system, to improve the information needs of health authorities and the Department of Health. It plans to introduce this either in 1992 or 1993. The introduction of ethnicity into the Korner system, which records how the Health Service is being used, is a major step forward which in future will provide important information for planners. Data will only become meaningful when the 1991 census is analysed as it has an ethnic question which will provide the denominator for this population.

The next important steps the Department hopes to take is through the review process, to monitor contracts to make sure that they cater for the needs of the whole population including the ethnic minorities. It is also going to analyse the first round of Director of Public Health Reports to see if ethnicity is reflected in them and encourage this in future. This would help CHCs and health authorities by providing useful information for them to be aware of the health and disease patterns of the ethnic minority communities. The Department has also made it clear that Quality Assurance programmes need to take account of the needs of ethnic minorities and demonstrate that services are appropriate for them.

The review process last year highlighted that Family Practitioner Committees were not reflecting the needs of ethnic minority communities. The FPCs need to include ethnic minorities in their population health profile, and address the issue of female GPs for ethnic minority women who sometimes do not use the services because they do not want to be examined by male doctors. FPCs also need to collaborate with DHAs towards improving services locally. Membership of health authorities is another major issue, and our Minister has recently written to all regional chairmen, and has particularly highlighted this to districts with 10% and over ethnic minority population to make every effort to appoint ethnic minority members. We are also considering the introduction of ethnic monitoring of the membership of health authorities.

I would like to make some suggestions to Community Health Councils about addressing ethnic minority health issues. Firstly, CHCs need to develop an equal opportunity policy, understand the philosophy of the equal opportunity policy, and then make sure that they develop a strategy accordingly. CHCs need the data on ethnic minorities which hopefully will be provided by the census' data and Korner system so that they can critically look at the services that are being provided for members of their population. CHCs need to challenge decisions which do not incorporate the needs of ethnic minority

communities. It is important that they monitor the quality of services to ensure that they reflect the needs of the whole population. They need to consult the community widely, particularly at the grass roots.

Communities need information about their rights, but ethnic minority communities often do not know what they suffer from and also are not aware of important information on health services generally. This important information needs to be disseminated to the community so that they can participate with the health workers to improve their health. Training of CHC members is important and members from ethnic minority communities must not just represent ethnic minorities, but play a wider role in representing both black and white people of their area. There needs to be good liaison with the voluntary sector and CHCs. CHCs need to develop further strategies so that they can identify the right kind of black and ethnic minority organisation groups or individuals whose views they can seek. CHCs can help health authorities to conduct population health surveys which should include ethnic minorities too.

We need to raise awareness of communities too, so that they begin to see CHCs as their friends and as a place where they can go and express their anxieties and feelings. Finally, I would like to emphasise again that ethnic minority needs are not special needs, but are different needs. Since ethnic minorities are part of the local population that health authorities and CHCs serve, it is important that they are invited to particpate in planning and promoting health issues.

WORKSHOP REPORTS

WORKSHOP 1: HANDLING AND CHALLENGING RACISM

Facilitator: Richard Wiles, Secretary of West Lambeth CHC

This workshop did not aim to provide any definitive answers to the task of challenging racism, but rather was intended to be a forum in which CHCs could discuss and share their ideas and experience of good practice. The responsibility for addressing the issues of racism falls squarely on the shoulders of white people, and therefore it was felt appropriate that a white person should be leading the discussion on challenging racism.

Three key components of racism were identified:

* **Attitude** - this comprises a hostile belief or set of beliefs, based upon prejudice, about a racial group or groups

* **Activity** - acting in a way that is determined by such attitudes

* **Inequality and power** - in this sense means using one's status/influence in such a way that the actions result in people of other racial groups being disadvantaged or discriminated against.

Cutting across these three main features of racism are the individual and institutional dimensions of racism. It was generally agreed that institutional racism is less taboo as a subject than individual racism, because it is impersonal and unconscious, whereas the latter is more conscious and harder to confront. Individual racism is as often to do with ignorance as with a deliberate attempt to insult.

An example of personal unconscious racism might be where a receptionist at a GP's surgery passes a comment about "these Pakis" to another receptionist. An example of unconscious and institutional racism is reflected in the very high rates of occupancy of locked psychiatric wards by Afro-Caribbean people. It is clear that the parameters surrounding racism determine how it can be dealt with.

The workshop considered some of the ways in which CHCs may challenge racism, as part of their responsibility to challenge inequalities of power and enable users of health services to obtain the best possible services regardless of their ethnic origin. It was pointed out that there is legislation governing discrimination on grounds of race, and CHCs need to be aware of their legal responsibilities in this regard. There are three main areas in which CHCs have a responsibility challenge racism.

1. Racism in clients

Examples were given of CHCs which had faced racist clients and a variety of suggestions were made as to how this could be tackled:

* CHCs must take a much firmer line against racism.

* Unacceptable behaviour of clients and CHC members, in terms of ill-informed remarks and language, should be tackled in a straightforward manner to make clear that the CHC tries as far as possible to speak for all members of the community.

* CHCs could adopt the same policy as the Citizens Advice Bureaux and have a very large prominent poster declaring an anti-racist policy - this would challenge the belief of some clients that the CHC might condone a racist client's attitudes

There was discussion on whether it is racist for a client to want a doctor from their own culture. It was suggested that people from the indigenous majority culture would be racist if they demanded, for example, a white doctor, but that people from the Asian community would not be considered racist if they wanted a doctor who both understood their language and their culture. It was generally felt that although second generation ethnic minority people may not experience language barriers they nevertheless do suffer racism.

2. Racism within the health professions

Some of the problems recognised were as follows:

* **Doctors from ethnic minority communities** experiencing greater racism from white fellow professionals than from their clients. They are sometimes prevented from practising by their Local Medical Committees. Despite clear financial benefit for existing practices where there are insufficient doctors the ethnic origin of a doctor applying to practice in a deprived area is also seen as a factor

Positive steps taken by health service providers include an instance when the Family Practitioner Committee supported the appointment of link workers attached to GP practices, many of whom had originally been hostile.

CHCs can play a positive role in the following ways:

* **Staffing issues** - CHCs represent the local community and an aspect of this role is to encourage access to fair employment opportunities for the local community.
- CHCs can publicise the lack of higher grade ethnic minority staff
- put pressure on health authorities to implement equal opportunities policies.

3. Racism within the NHS: policy and practice

Various techniques for challenging policy which has clear discriminatory effects on ethnic minorities include:

* **Persuading the local FPC** to set up an ethnic minority working party;

* **Threatening to refuse to meet the FPC** under its statutory annual meetings and report the FPC to the Department of Health;

* **Enlisting the support of the FPC** general manager in dealing with racism among the medical profession or within the FPC itself;

* **Raising people's awareness** in a friendly and informal way to tackle racism arising largely from ignorance;

* **Using the formal review process** whereby the RHA has powers over the DHAs;

* **Challenging DHAs' arguments** that low levels of funding are the reason for not providing adequate services for ethnic minority communities - DHAs have to provide services for the whole community and "soft" money like joint finance and inner city money are not sufficient alone;

* **CHCs could introduce ethnic monitoring** of the number of complaints dealt with by CHCs and the number of which have a racist component.

* **Press for the provision of translation services** by health authorities and FPCs - official translators are not always appropriate as they can be intimidating and unhelpful for some patients.

WORKSHOP 2: MAKING YOUR CHC MORE RACE AWARE
Facilitator: Lesley Pattenson, Health Education Authority.

This workshop aimed to focus on some of the theoretical and practical aspects of the CHC's role in relation to the health needs of the racial and cultural groups in its District. It considered ways in which the organisation and practice of the CHC may promote or impede sensitivity to these issues and the ability to address them.

The wider context of equal opportunities should also be considered; CHCs should attempt to be more sensitive and responsive to minority groups as a whole and to see issues of race and health as part of a wider range of multiple disadvantage. The success of the CHC in addressing these issues is key to achieving credibility and enhancing the public image of the CHC in its work.

It was noted that the diversity within and between districts and the different size and nature of minority ethnic groups in different localities made the task even more challenging. It was stressed that initiatives need to be realistic and that if an initiative fails, it should not be assumed that the black and minority ethnic groups involved are to blame.

Some of the ways in which CHCs can work to become more race aware in their structure, membership and work include:

CHC policy

* **Adopt an equal opportunities policy**, with strategies for putting it into operation, monitoring and reviewing its success. Training for CHC staff and members should be part of this.

CHC structure and meetings

* **Set up a working party** to look at black and minority ethnic issues with broad representation from local black and minority ethnic groups. It could consist of members from outside the CHC as well as CHC members. A working party shifts the resonsibility from individuals onto a wider group, which can be more supportive. Ensure that issues and recommendations are fed back to the full CHC.

* **Ensure time for consideration** of the needs of black and minority ethnic communities in every discussion of services.

* **Do not always presume black and minority ethnic members** will raise issues of concern to the black and minority ethnic community.

* **Ensure good publicity for CHC meetings** reaches all parts of the local community

* **Venues** for meetings should be familiar and acceptable, with disabled access and good public transport links; other services should be available, such as interpreters, signers, childcare and creche facilities on request.

* **Appropriate times and dates for meetings**, for example, avoiding religious festival days.

CHC membership

With such variations in the racial and cultural complexion of each community, it is almost unrealistic to expect the CHC to represent a true cross-section of the local population. However, ways in which the CHC could enhance its black and minority ethnic membership include:

* **Information to local communities** on the work of the CHC and how to become a member/co-opted member

* **Set a minimum requirement** of the number of members from the black and minority ethnic communities which the CHC will aim to have.

* **Press for it to be a statutory requirement** that CHCs widen their scope of membership to include people from black and minority ethnic communities.

* **Make recommendations to the RHA** about appropriate members from black and minority ethnic communities who could be appointed as RHA representatives and ensure that the RHA has a list of voluntary organisations which are eligible to vote/be elected.

* **Support networks for new members**, including induction.

* **Use co-option** to the full and encourage co-opted members of black and minority ethnic groups to become full members.

Information

* **Make use of sources of local practical information** on population statistics, demographic data and cultural and religious issues and needs, such as festival dates and local minority ethnic newspapers.

* **Canvas opinions and carry out surveys** of the opinions of black and minority ethnic communities, both community leaders, organisations and grass roots. Try to be systematic about this.

* **Monitoring**, using checklists for visits taking into account the needs of black and minority ethnic communities and invite members of these communities onto visiting panels.

* **Influencing contracts and quality assurance** if possible, by incorporating the needs of the black and minority ethnic communities and consulting them on this.

* **Make full use of ACHCEW Information Service** and other CHC reports and surveys on the needs of the multi-cultural community.

Involvement of the local community

* **Build up contacts and network the local community** at all levels and keep/update a list of all contacts in the district.

* **Maintain links with key groups,** such as the local Community Relations Council, Equal Opportunities Unit and individual organisations.

* **Use fieldworkers,** such as Health Visitors, District Nurses etc to provide contacts and information.

Publicity

* **Send publicity/press releases/advertisements** to minority ethnic newspapers, local radio stations and other organisations' newletters.

* **Ensure language/visual images are appropriate** and that material is translated.

* **Keep a list of relevant interpreters** to call upon if someone approaches the CHC without spoken English.

The lack of complaints registered by people from black and minority ethnic communities was seen as an indication of the way in which the complaints system and the health service in general is inaccessible to many people from these communities.

WORKSHOP 3: MEETING CULTURAL NEEDS
Facilitator: Ramesh Talwar, Greenwich MIND.

It was noted that the NHS was originally set up primarily for white Anglo-Saxon people and that efforts to incorporate the needs of minority ethnic groups are taking place slowly. Definitions of culture are problematic, but it was agreed that culture is not static, but individual and specific.

The workshop firstly identified some of the problems which are encountered in attempts to meet cultural needs and then addressed ways in which the health service and CHCs can work to improve such efforts. Some problems which were identified included the following:-

* **Poor access** to health services for people from many cultures - this often occurs because the services are not flexible enough.

* **Poor information** available to people from minority ethnic groups on services available and how to make the most of them

* **Stereotyping** - people from minority ethnic groups are often stereotyped by health staff, because of ignorance and because of images perpetuated by the media. Communication between people and representation of different cultures can help to overcome this barrier.

Positive steps the NHS can take

* **Acknowledge the differences** of each culture and find out what their needs are, such as different types of food.

* **Training for staff** in meeting cultural needs

* **Assessment of who is using health services** - this will help to identify unmet need

* **More flexibility** in service provision will improve the accessibility of services

Positive steps CHCs can take

* **Make CHC staff and members aware** of the issues:
- how racism operates in institutions
- identify the community and their needs
- facilitate health forums
- check if needs of ethnic communities are being met on visits to health service premises.

* **Make contact** with different local cultures:
- meet people at the grassroots and not just religious and community leaders to identify their needs.

* **Provide information** on CHCs in an accessible form.

* **Raise issues** from minority ethnic groups with the NHS and recommend improvements.

* **Develop written policies** and operational strategies to ensure that the needs of local minority ethnic groups are included in all the CHC's work.

* **Endeavour to ensure that CHC membership is representative** of the local community and all the different cultures - RHAs and local authorities should be encouraged to nominate appropriate representatives.

CHCs should recognise that making personal contact with local groups and including their needs in all aspects of the CHC's work will take time and commitment; it will require a development of mutual trust over a period of time. Moreover, meeting cultural needs may involve negotiating around personal and political battles.

WORKSHOP 4: RACE AND MENTAL HEALTH
Facilitator: Yvonne Christie, King's Fund Centre.

The workshop agreed that there are differences in the treatment of people in the field of mental health and that there are specific problems which people from black and minority ethnic groups experience in both diagnosis, treatment and aftercare. The group looked at the particular issues of race and mental health which are of concern and then addressed the various ways in which services could be improved and CHCs could take positive steps towards more appropriate services.

The main issues raised were:-

* **Greater use of physical treatment** for people from black and minority ethnic groups - this includes the use of major tranquilliers (particularly for women) and Electro Convulsive Therapy (ECT).

* **High percentage of Afro-Caribbeans in detained wards** and in psychiatric hospitals

* **Involuntary patients** (under a section or a police escort) are 2-3 times more likely to be Afro-Caribbean people

* **Diagnosis** - schizophrenia seems to be more readily diagnosed in black people than the indigenous population

* **Effect of domestic and housing pressures** on mental health - black people leaving hospital are less likely to be given the choice of good supported housing

* **Lack of alternatives** offered to hospital treatment, such as appropriate psychotherapy

* **Medical system discriminates** - lack of awareness of consultants and other professionals of the various cultures of the service user. Behaviour is often not considered in a cultural context

* **Lack of information available** on medication and treatment

* **Lack of support services** for hospital discharge

* **Need for resources** to provide appropriate services, such as community care rather than psychiatric institutions

What CHCs can do

* **Monitor health authority plans** to establish whether the mental health needs of black and minority ethnic groups are being met, and recommend improvements where need is demonstrated

* **Monitor the disparity** between mental health services received by the white population and that of black and minority ethnic groups

* **Give support and practical help** to local groups to provide their own services, such as establishing one to one counselling for Asian women on tranquillisers relief, or helping to set up an advocacy worker post

* **Find out views** of the local black and minority ethnic community on mental health services, for example on the closure of psychiatric hospitals and the arrangements for community care

* **Monitor how many people** from black and minority ethnic groups are sectioned (possibly link into police and hospital figures)

* **Maintain links** with the local Community Relations Council

* **Distribute information** about local mental health services and the work of the CHC as widely and appropriately as possible to the local community